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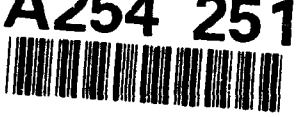

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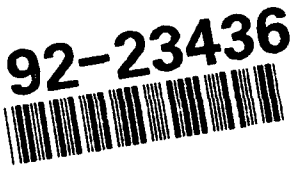

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ABSTRACT

Title of Seminar Paper: Paradigm Shift in Health Care: From Quality Assurance to Continuous Quality Improvement

Name of Candidate: Lori L. Montgomery

Seminar Paper Directed by: Audrey D. Gift, Ph.D., R.N.
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The concept of quality in health care is discussed throughout this paper, within an historical perspective, including key forces influencing quality assurance (QA).

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has been identified by Schroeder (1991a) as probably the most significant influence on QA structures and approaches in the United States. The revised nursing care standards delineated by JCAHO in the 1991 Accreditation Manual for Hospitals (AMH) will be discussed in this paper. A Systematic Internal Review (SIR) program to be utilized as a self assessment of compliance with the new standards is introduced. In addition, the monitoring and evaluation (M&E) process used to measure the quality of care as set forth by JCAHO is described.

The concept of quality and the shift from a traditional QA philosophy to a continuous quality improvement (CQI) philosophy is explored with implications for health care and nursing presented. The importance of nursing staff as well as an organizationwide commitment to and involvement with CQI activities is emphasized.

Paradigm Shift in Health Care:
From Quality Assurance to Continuous Quality Improvement

by
Lori Montgomery

Seminar Paper submitted to the Faculty of the Graduate
School of the University of Maryland at Baltimore
in partial fulfillment of the requirements for
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TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

Perhaps at no other time than the present have the issues of the cost and quality of health care, and the balance between the two, received so much attention. Changes in consumer awareness and financial reimbursement have compelled hospitals to re-examine both the quality and cost effectiveness of their health care delivery. The impact of personnel and programs are being re-evaluated (Gournic, 1989). In 1990, 12.2% of the gross national product was spent on health care and it is expected that these costs will continue to rise (Masters & Schmele, 1991).

A major challenge for leaders in the current health care environment is to balance the concern about the costs of providing patient care with the necessity of assuring a quality product. Many health care providers, employers and the federal government are actively seeking ways to decrease these costs. This has resulted in hospitals being pressured to identify care costs and deliver care more effectively and efficiently while maintaining quality care. Delivering the best care for the lowest possible cost becomes the challenge. Measuring productivity and outcomes becomes vital to assuring that health care monies are spent appropriately in delivering a quality product. A difficult issue arises in that although costs can be identified in an objective manner, quality has been more subjective in nature. The issue of quality in health care has been dealt with as a "soft" parameter, and as such makes it difficult to measure or define (Del Togno-Armanasco, Harter, & Goddard, 1991).

Graham (1990) cites the following as key factors fueling the rising interest in quality in the United States: rapid advances in medical technology; rising health care costs; increased government funding; growing consumer expectations coupled with a rise in

malpractice suits; proven poor level of quality; and a growth of service institutions.

The health care industry is currently witnessing a paradigm shift from the concept of traditional quality assurance (QA) to the concept of continuous quality improvement (CQI). The traditional QA approach of pointing fingers, primarily focusing on individual performance, and mainly problem performance, has caused many health care professionals to associate QA activities with a negative connotation. CQI is a more positive approach currently evolving in health care. A CQI philosophy has been used by industries to improve product quality and services. Health care is adapting CQI principles and tools with the hope of delivering health care more efficiently, decreasing costs and improving quality (JCAHO, 1991b). CQI focuses on improving the processes that affect outcomes. Whereas traditional QA may have been satisfied with not falling below a certain level of quality, CQI looks for opportunities to continually improve processes and to identify ways of doing things better. Improving processes is equated with increasing the probability of improved patient outcomes (Hospital Peer Review, 1990a).

In 1986, the JCAHO announced its major research and development project entitled the Agenda for Change, with the goal of improving health care quality (Nadzam, 1991). Included among the Agenda for Change initiatives are a shift from process to outcome measures of care (Jones, 1991), the revision of accreditation standards and the use of CQI principles. These initiatives are addressed throughout this paper. It behooves nurses, as well as all health care employees, to keep abreast of professional standards and quality care trends and issues.

CHAPTER II

HISTORICAL PERSPECTIVE OF QUALITY ASSURANCE

There is a long historical commitment to quality assurance activities. From 1854 to 1870 in Great Britain, the evaluation of care was stimulated by health professionals and focused on both the process of care and patient outcome (Bull, 1985). Florence Nightingale is usually recognized for the first documented studies in nursing and health care (Lang & Clinton, 1984). During the Crimean War Nightingale introduced standards of infection control which resulted in reducing the mortality rate of British soldiers from 42 percent to 2 percent (Duquette, 1991). During the war she studied the quality of hospital care that was available to the British Army. Data concerning hospital deaths organized according to diagnostic category and unsanitary conditions were used to reason that by improving sanitation, deaths could be reduced and outcomes improved. In 1863 she suggested a system relating the use of hospital beds to health indicators so that hospital beds could be used efficiently and effectively. In Nightingale's Notes On Nursing she stated rules of good nursing which might be viewed as early process standards for nursing practice (Bull, 1985).

The outcome approach to QA was continued by a British physician, Emory Groves. In 1908 he surveyed 50 hospitals concerning patient mortality related to surgical procedures. His study cited the need for development of a standard classification of diseases and operations to allow data comparison from different hospitals and the need to establish a follow-up system for certain diseases to permit evaluation of long-term results (Bull, 1985).

In the United States during the early 1900s, poor health care outcomes tended to be seen as something beyond human control rather than related to a practitioners' abilities or the patient's access to care. The major impetus for quality assurance came from health care

professionals. The focus continued to be mainly patient outcomes, however structure began to be emphasized (Bull, 1985).

In the field of medicine, some physicians realized a need for changing medical eduction. Dr. Abraham Flexner's report in 1910 revealed the poor quality of medical education throughout the United States and was influential in the closing of numerous U.S. medical schools. This report was instrumental in requiring more difficult admission requirements and changes in curriculums (Graham, 1990).

It was also during this time that legislation concerning the registration of nurses was being organized by state nurses' associations. There was concern for improving nursing's educational base and this was related to licensure efforts. Legal requirements were outlined by state licensure laws. The purpose of nurses and physicians developing structure standards was for protection of the public against unsafe practitioners (Bull, 1985).

In 1916 Dr. Ernest Codman, a surgeon, studied the outcomes of patient care. This study addressed issues similar to those used to examine the quality of care today. Some of these issues included the patient's health/illness behavior, the presence of co-existing diseases, a consideration of the severity of disease, institutional accreditation, licensure or certification of practitioners and economic barriers to health care (Graham, 1990). Codman's work led to the origin of the Hospital Standardization Program of the American College of Surgeons in 1918. The use of standards and granting of accreditation for complying with these standards was part of this program. The Joint Commission for the Accreditation of Hospitals (JCAH) later adapted standards from this program (Bull, 1985).

From 1920 to 1940 there was little work done in the quality assurance area. In the late 1940s and 1950s interest resumed in evaluating the quality of care with process and structure, rather than

outcome, being emphasized. Consumer interest in and demands for greater access to health care increased. The Hill Burton Act of 1946, a federal program, provided public funds for building new hospitals and expanding and modernizing existing ones (Lang & Clinton, 1984).

In 1952 the JCAH was established to assume responsibility for the accreditation program set forth by the American College of Surgeons. The purpose of the JCAH was to encourage voluntary attainment of consistently high standards of hospital care (Graham, 1990). The criteria initially developed by the JCAH emphasized structure standards (Bull, 1985).

Both medical and nursing care studies done in the 1950s focused on the process of care. Significant deficiencies in care were found. Nursing focused on the process of nursing care and nurse-patient interaction. Additionally, nursing organizations developed structure standards (Bull, 1985).

The 1960s were marked by heightened public expectations about health care. Human rights, consumer protection and the idea of health care as a right were in the forefront. With passage of the Social Security amendment of 1965, which enacted Medicare and Medicaid, the federal government became involved in providing financial coverage for medical care of the poor and elderly. Government regulation flowed from the legislation and structure standards were required in acute care settings and nursing homes (Bull, 1985). The Medicare legislation instituted utilization review (UR) activities. These activities were designed to assure that the services covered by the program were necessary and that an appropriate facility provided the medical services. This was the first federal attempt to institute control measures. Further legislation in 1966, the Comprehensive Health Planning and Public Health Service Amendments, attempted to link health

spending with better planning and controls and to prioritize federal and state funding for health programs (Lang & Clinton, 1984).

In the professional arena, nursing quality assurance activities were directed toward methods of assessing process. In an attempt to evaluate the quality of nursing care provided, process audits were used. Audits included multiple criteria which allowed nurses to inspect and evaluate the process of providing patient care (Duquette, 1991).

Although the major focus of quality assurance activities during the 1960s was on process, JCAH requirements still stressed structure elements. A 1960 nursing study by Aydelotte and Tener attempted to relate structure, process and outcome, however, results indicated no relationship between nursing activities and patient outcomes. On the medical side, in 1966 Donabedian differentiated among structure, process, and outcomes and encouraged development of criteria for evaluation of outcomes. Thus the 1970s saw a mixed focus among structure, process and outcome (Bull, 1985).

Quality assurance grew rapidly in the 1970s due to a number of factors. An increased interest in professional accountability was due to the spiraling costs of health care and concern about inflation. There was more consumer involvement in health planning. Talk of National Health Insurance sparked discussions of quality and cost.

Legislation was enacted as a result of rising cost. In 1972 the Professional Standard Review Organization (PSRO) was enacted with the purpose of creating a system of peer review. This was physician oriented and involved the review of health care provided in federally financed institutions. Noteworthy is that only care rendered in nursing homes or hospitals came under review. The implementation of PRSOs was hampered by special interest groups. Physicians did not appreciate being controlled by government. Hospital administrators felt left out as they were not directly involved with PRSOs, yet hospitals were

absorbing the economic impacts. Additionally, since PSROs could possibly do away with the need for the JCAH, the Joint Commission viewed itself in competition with them (Bull, 1985).

In 1974 the American Nurses' Association (ANA) was given a government contract to establish screening criteria to evaluate nursing care quality and effectiveness. In addition, the ANA was to develop guidelines for nursing's involvement with PSRO review processes. In the early 1970s the ANA developed standards of practice addressing both structure and process. The ANA also adapted Norma Lang's quality assurance model, the purpose being to help nurses implement programs that would assure quality nursing care. Use of the model encouraged nurses to direct attention to patient outcomes and to the relationships among structure, process and outcome (Bull, 1985).

Nursing process audit tools continued to be developed and used during this period. The Joint Commission introduced the Peer Evaluation Program (PEP) Primer, which focused on outcomes. This program incorporated a retroactive process audit to be used if a certain nursing care problem was identified in the process audit. During the 1970s there was a renewed focus on patient outcomes and the development of additional tools to measure the quality of patient care (Bull, 1985).

The 1980s saw changing technology and values with more people interested in the quality of health care. The Joint Commission instituted new standards in 1981 requiring an integrated hospitalwide quality assurance program. The focus of this program was to be on problems concerned with patient care (Bull, 1985).

Rising health care costs directed attention toward cost effectiveness and cost containment of services. Evaluation of PRSOs proved that they were not effective in containing costs. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 and the Social Security Amendments of 1983 enacted legislation providing for a Prospective

Payment System (PPS) for Medicare recipients. This system was based on Diagnosis Related Groups (DRGs) where predetermined rates are paid to hospitals for each patient within a certain DRG. DRGs do not take into account differing lengths of stays or nursing care requirements among similarly diagnosed patients (Bull, 1985). The PPS increases the need for an effective review system since hospitals have motives for inappropriate diagnosis classification and increased patient admissions and readmissions (Graham, 1990). A challenge facing nurses (and physicians) due to the PPS is establishing standards which promote cost effectiveness while assuring quality care (Bull, 1985).

The 1983 Social Security Amendments also mandated institution of Professional Review Organizations (PROs) by October 1984. PROs were intended to replace PSROs (Bull, 1985). Medicare services provided by hospitals are reviewed by PROs to ascertain the quality of care, medical necessity and soundness, and if the care was rendered in an appropriate facility. PROs have more power than PSROs did in recommending punitive steps against physicians and hospitals. The intent of PSRO and PRO programs were to review both the quality and cost of health care (Graham, 1990).

In 1986 the Joint Commission announced a new project called the Agenda for Change, the initiatives and goals of which will be discussed later in this paper. Additionally, in 1987 the JCAH Board of Commissioners approved the name change of the Joint Commission to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This was done in an effort to reflect the broad spectrum of health care organizations offered educational and accreditation services by the Joint Commission (JCAHO, 1988a). Also in 1987, the JCAHO introduced a ten-step method for patient care monitoring and evaluation (M&E). This process proposes a step-by-step procedure for monitoring and evaluating

professional practice (Duquette, 1991). M&E will be presented in Chapter Four.

A number of factors have contributed to the current concern about quality assurance in the United States. These factors include but are not limited to: rising medical care costs, increased funding of health care by government, advances in medical science and technology, documented poor quality of care, an increase in consumer awareness and expectations accompanied by rising malpractice litigation and a growth of service institutions. These factors have combined to heighten the focus on quality assurance activities and other "quality concepts" such as quality assessment, quality improvement and total quality management. Health care is facing many quality innovations and revisions, including a trend to focus monitoring activities on outcomes of care rather than performing structure and process audits (Cassidy & Friesen, 1990). The concept of quality will be discussed in Chapter Three.

CHAPTER III

QUALITY CONCEPTS

Defining Quality

There have been questions not only regarding how to measure quality, but how to define quality as well. The concept of quality and therefore quality assurance has been seen as mostly subjective, difficult to measure and somewhat nebulous. It is difficult to define quality considering all of its dimensions. The definition of quality depends upon who is doing the defining. Administrators may rate quality according to services rendered in relation to costs. Patients may judge quality according to interactions with health care workers (Graham, 1990). Health care providers may judge quality according to complications encountered, length of stay, and patient outcomes in relation to quality of life.

Graham (1990) states that a definition of quality includes the "art" of the care as well as the scientific, technical aspect of care. The way that health care professionals conduct themselves in respect to their patients is considered the art of care. This is sometimes measured by patient satisfaction.

Many authors have attempted to define quality. For purposes of this paper, two definitions will be presented. Thompson, as cited in Graham (1990, p. 9), defines quality as the "optimal achievable result for each patient, the avoidance of physician-induced (iatrogenic) complications, and the attention to patient and family needs in a matter that is both cost effective and reasonably documented". This author would like to expound that quality should involve all health care or any service oriented personnel rather than just physicians as noted in Thompson's definition. Nursing and all ancillary and support services are either directly or indirectly involved in the quality of care.

The Joint Commission notes that a definition of patient care quality causes uneasiness in the health care area. However, the Board of Commissioners directed the development of a definition of patient car quality which would serve as a reference for the M&E activities mandated by the accreditation process. This definition was developed in view of increasing public demand for quality care and the goals and objectives of the JCAHO's Agenda for Change (JCAHO, 1989). Patient care quality, as defined by the JCAHO, is "the degree to which patient care services increase the probability of desired patient outcomes and reduce the probability of undesired outcomes, given the current state of knowledge" (JCAHO, 1989, p. 310). Therefore, from the discussion thus far, a definition of quality must consider the perspectives, values and purposes involved. The purpose for assessing quality such as accreditation, cost effectiveness or for improving quality must be considered. Additionally, one must ask quality based on whose perspective and what values? Values may differ among the perspectives of patients, institutions and health care professionals. Quality must be viewed as a dynamic concept which evolves and changes as resources, values and knowledge change (Graham, 1990).

From Quality Assurance to Continuous Quality Improvement

There is currently a change in thinking about quality in many health care organizations from quality assurance (QA) to continuous quality improvement (CQI) activities. While the strengths of QA are included in CQI, CQI has a broader scope and a more positive approach compared with the negative connotations occasionally associated with QA. The CQI movement involves using the philosophy and principles that many industries are using or have used to improve the quality of services and products (JCAHO, 1991b).

JCAHO (1991b) suggests that the concept of CQI involves focusing on the following areas:

- the fundamental activities of the organization such as the governing body, management and support services as well as direct patient care.
- an organizationwide coordination of efforts.
- effective measures of performance to assure reliable data collection.
- the processes having significant effects (both direct or indirect) on patient outcomes and opportunities for improving these processes.
- Using the CQI approach for improving patient care involves examining series of activities that make up fundamental services throughout the hospital (JCAHO, 1991b).

Deming's 14 Points on Management

One of the foremost "gurus" concerned with improving quality is W. Edwards Deming, a statistician and consultant (Main, 1986). Although almost ignored in the United States for many years, Deming assisted in rebuilding the Japanese economy after World War II. He helped the Japanese develop their industrial culture which is concerned first and most importantly with quality and continuous improvement. The effectiveness of Deming's management methods is evidenced by the world market standings of Japan's quality products (Gillem, 1988).

Deming stresses that businesses/organizations have both internal and external customers. The internal customers of a hospital include different departments within the organization. Each department receives a work product from somewhere else within the hospital and each department supplies things to other departments. External customers of hospitals include, but may not be limited to patients, physicians and purchasers of health care such as insurance companies, employers and health maintenance organizations. Two essential steps proposed by Deming, in continually improving quality, are carefully listening to

external customers and improving internal customer-supplier alliances (Gillem, 1988).

Deming initially proposed statistical process control methods; however, more recently he focuses on a management philosophy including 14 points (Main, 1988). Gillem (1988) discusses the following 14 points outlined in Deming's book Out of the Crisis as they relate to health care:

1. Create constancy of purpose for service and improvement. The leaders of a health care organization should be involved in developing quality improvement strategies and incite a long term commitment to improved patient care and increased productivity. Future organizational goals must be defined and communicated to all employees.
2. Adopt the new philosophy. This involves coming to understand the possibility of doing things right the first time. This should become routine and less than this is unacceptable. Procedures that are performed incorrectly result in costs involved with waste and rework. Stressing quality should eventually translate to lower costs.
3. Cease dependence on inspection to achieve quality. By initially building quality into a product, the need for mass inspection can be eliminated. The present use of audits and reviews in health care are aimed at isolating substandard performance. Rather than assigning blame, quality improvement efforts focus on instituting information systems which highlight opportunities for improving care, and measurement systems intended to evaluate the effectiveness of implemented changes.
4. End the practice of awarding business on price tag alone. The total cost of use, not only purchase price, must be considered. The cost of correcting faulty equipment and other supplies may

exceed any savings of a lower purchase price. Hospitals should move toward establishing long-term partnership relationships with vendors whose supplies/equipment work correctly every time.

5. Constantly and forever improve the system of production and service. The process for continuous improvement involves studying a process to determine any areas for improvement, making the improvement, evaluating the results, learning from the process and repeating it whenever necessary. This process parallels the nursing process of assessing, planning, implementing and evaluating. However, the nursing process is applied to individual patients, whereas the continuous improvement process is systemwide. Management has the responsibility of assuring that each employee knows the hospital's mission and has a precise definition of how their hospital defines quality. This understanding will enable employees to make considerable improvements.
6. Institute on-the-job training and retraining. Employee training must include not only education for actual job performance and why it is being done, but methods of using information and quality improvement as well. Employees must be viewed as an organization's most valuable asset and should be led, rather than driven by management.
7. Institute leadership. The goal of supervision should be to help people and equipment do a better job (Hospital Peer Review, 1988). Managers must understand the system in order to work towards improving it. System improvement may hinge on the managers' abilities to quantitatively describe system performance and to apply this information in planning improvements.
8. Drive out fear. This allows workers to work effectively for the organization by not being afraid of making suggestions for

improvement. Fear of speaking out reduces the potential for improvement. Professional and hierarchial role segmentation need to be abolished in order for cooperative quality improvement efforts.

9. Break down barriers between departments. Teamwork rather than competition between departments should be emphasized. Resources must be shared and problems solved among departments for the benefit of the patient. Reducing barriers between departments may reduce the amount of rework caused by errors. Interrelated processes form the health care delivery system. Each process has an input supplier and a customer receiving the output. Each employee trying to meet the needs and expectations of both their internal and external customers should dissolve departmental barriers.

10. Eliminate exhortations, slogans, and targets for the work force such as "improve quality" and "be more productive". These insult employees by assuming they don't want these things. The system, and not the workers per se, is usually responsible for the causes of low quality and/or low productivity.

11. Eliminate numerical quotas and goals for the work force and for management. Quality will suffer if the first focus is on quantity. The goal is for every employee to do their best, concerned first with accuracy. Management must "walk the talk", emphasizing that quality rather than quantity should be most important.

12. Remove barriers to pride of workmanship. Performance appraisal in place at many hospitals focuses on recognition and compensation systems that are not depictive of actual work that the employee could take pride in. Many performance appraisal systems emphasize individual employee accomplishments, providing financial rewards

for a person's isolated performance. Management behavior and appraisal strategies should realize that people work together. Increasing the effectiveness of working together should be emphasized over promoting individual performance. The focus should be on improvement of employee performance over time which may allow employees to experience the pride in, and take credit for, a job well done.

13. Institute a vigorous program of education and self-improvement. There is an increase in the value of an employee who is motivated to learn regardless of the subject. It need not be related to the employee's job. It is vital to keep the minds of people working. Many budget cuts eliminate or reduce the amount of continued learning opportunities offered to employees. Personal development of its workers should be a priority for employers. Employees can return tenfold to the organization that which they gain from educational opportunities, whether related or unrelated to their position within the system. This is an investment employers cannot afford to pass up.
14. Put everyone to work on the transformation. Each and every person must contribute their efforts in order to bring about this change. The total hospital work force must be committed to and work towards continuous quality improvement. Much more will be required of leaders (Gillem, 1988).

JCAHO's "Principles of Organization and Management Effectiveness" and the Agenda For Change

Recognizing the vital importance of an organization-wide commitment to continuous improvement of quality of care, the "Principles of Organization and Management Effectiveness" were adopted by JCAHO. These principles serve to emphasize that the quality of care received is

the result of a united effort of everyone involved (directly or indirectly) in managing the organization and supporting or providing patient care (Roberts, Schyve, Prevost, Ente & Carr, 1990).

These eleven principles, some of which have familiar undertones of Deming's principles, will be discussed briefly.

I. Organizational Mission

The organization's mission statement should clearly reflect its commitment to continuous improvement of patient care quality. Measurable objectives, strategies, and action plans should reflect this commitment. Governing bodies and hospital leadership should mutually develop and regularly evaluate the organization's mission statement and plans.

II. Organizational Culture

The culture of the organization encourages everyone who uses or provides the organization's services to participate in the continuous improvement process. Those who will be affected by decisions should be urged to participate in appropriate decision making processes.

III. Organizational Changes

Opportunities for change should be monitored continuously by all organizational members. Opportunities may include, but are not limited to, access to care, patient volumes, external environmental influences and quality of care satisfaction by patients, families, hospital employees and payers. Financial resources need to be assessed and planned for. Changes considered appropriate for improving patient care quality should be implemented.

IV. Role of Governing Board and Managerial and Clinical Leadership

Leaders must express the organizational commitment to continuous improvement in patient care. Policies, objectives and delineations of responsibility and authority should reflect leaders' roles. Leaders

seek feedback from both internal and external customers as a strategy for evaluating and improving patient care quality.

V. Leadership Qualifications, Evaluation, and Development

Well qualified people possessing the necessary attitudes, skills, knowledge and vision for continuously assessing and improving patient care quality should make up the organization's governing board and leadership. Leadership should regularly evaluate its effectiveness and involvement in quality improvement efforts. Opportunities for the growth and development of leaders should be planned to help them with continuous quality improvement efforts.

VI. Independent Practitioners' Qualifications, Evaluation and Development

The organization should employ an adequate number of practitioners for providing patient care. These practitioners are competent and are evaluated both initially and at regular intervals for judging clinical performance and competence. They are committed to and participate in the continuous improvement of quality patient care. These practitioners have opportunities available to them for their growth and development.

VII. Human Resources

Recruitment and retention efforts ensure an adequate number of competent practitioners and support personnel who are committed to, and actively take part in, the process of continually improving patient care quality. Regular evaluations of competence and performance are done. Human resource policies and practices also address opportunities for the growth and development of all personnel to help them continually improve patient care quality.

VIII. Support Resources

Technology, equipment and facilities are sufficient to support the mission statement and planning efforts.

IX. Evaluation and Improvement of Patient Care

Organizational governing bodies and leadership oversee the monitoring, evaluation and continuous improvement of patient care efforts. This assessment process involves an organization wide integration of risk management, utilization review and quality assurance data. Also included are feedback from internal and external organizational customers. Data analysis is useful in the development of short and long term plans for changes to improve patient care quality.

X. Organizational Integration and Coordination

All units and personnel within the organization need to understand their interdependence and the importance of working with one another to constantly improve the quality of patient care. Organizational policies should foster the necessary coordination, communication and conflict management between appropriate units.

XI. Continuity and Comprehensiveness of Care

Networks are instituted and maintained with care providers external to the organization to improve the access, continuity and completeness of patient care. Optimally this will improve the quality of patient care (Roberts, Schyve, Prevost, Ente & Carr, 1990).

Continuous quality improvement is one of the focal points of the Joint Commission's "Agenda for Change". In short, the Agenda for Change is devoted to finding better ways for enhancing the quality of health care to the public (JCAHO, 1990c). The three initiatives that make up the Agenda For Change include (1) a revision of standards to foster the application of continuous quality improvement principles; (2) indicator development and use, including establishment of an indicator data base for monitoring and comparison of hospital performance; and (3) a change in the accreditation survey process directing attention to organizational performance (JCAHO, 1991a).

The first standards initiative is presently the highest priority and the most encompassing. This initiative involves deleting several standards, many that address structural requirements. Standards promoting continual quality improvement and organizationwide instead of departmental performance will be added (JCAHO, 1991a). The standards that result should address only those functions which are vital to quality care (Roberts, Schyve, Prevost, Ente, & Carr, 1990).

Recognizing areas (and taking actions) for patient care improvement is addressed in the monitoring and evaluation (M&E) process. JCAHO's revised nursing standards incorporate QI activities into nursing care delivery and focus on an organizationwide commitment to quality improvement (QI) (Hospital Peer Review, 1990a). Although QI differs from QA, QI will not eliminate the need for traditional quality assurance. Instead of using M&E to judge if something is "good enough" one should apply M&E information to determine if something can be "done better" (JCAHO, 1990c). Therefore, ongoing M&E will continue to be needed. The traditional QA mindset may be satisfied with knowing there is a level of quality and believing things are okay as long as there is no drop below that level. QI involves continually trying to improve the processes with the goal of improving the probability of quality patient outcomes (Hospital Peer Review, 1990a).

An organizationwide commitment to QI was mentioned previously. This entails every employee in an organization attempting to do their jobs better rather than trying to achieve a minimal level of competence in order to meet QA standards (Gillem, 1988). The responsibility for QI rests with the leadership of the organization--management per se. In the past the QA department had the responsibility for maintaining the quality of care provided. Three important concepts of QI are leadership, developing a customer/service orientation and teamwork. These should not be new to hospitals but hopefully the recent emphasis

on QI will revitalize the commitment to these concepts. The next chapter will discuss the revised nursing standards set forth by JCAHO in their 1991 Accreditation Manual for Hospitals (AMH) and the M&E process.

CHAPTER IV

NEW STANDARDS FOR NURSING CARE

This chapter will present the new standards for nursing care set forth by JCAHO within the context of a proposed revision of a Systematic Internal Review (SIR) program. The SIR program revision was done by this author during clinical assignment at a local Baltimore hospital and in conjunction with the hospital's Nursing Quality Improvement Coordinator (NQIC).

Overview of Systematic Internal Review Program and the New Nursing Care Standards

The purpose of the Systematic Internal Review (SIR) program at this hospital is to establish a policy and procedure for the internal review and evaluation of Nursing Service. This program is a self assessment that systematically reviews the service's compliance with external review standards. These external standards include those derived from JCAHO. The JCAHO's "Agenda for Change", including the revision of nursing care standards, required the SIR to be rewritten to reflect the revised standards.

The review process is to be ongoing with completion every two years. Nursing staff members are assigned to conduct reviews on sections of the standards and to report the findings in writing to the NQIC. The NQIC in turn communicates the findings to appropriate hospital committees (Systematic Internal Review, 1988). The coordination of the SIR program is the responsibility of the NQIC.

Those nursing staff assigned to actually perform SIR assessments in the future should become quite familiar with the new standards. Nursing policies and procedures will need to be reviewed and revised as necessary to assure they are consistent with the new nursing standards. Future continued use of the proposed revised SIR program can be viewed

as supporting the institution's commitment to compliance with the JCAHO's nursing standards and their "Agenda for Change". It is noted here that the SIR only outlines the hospital's standards for nursing care. Nursing service will also need to assure their compliance to JCAHO standards in other areas which include but are not limited to, infection control, special care, pharmacy, and safety.

The new standards were developed by a 24-member task force which included a varied representation of nursing positions and organizations. The intent of the new standards is to assist health care organizations to focus on the improvement of the quality of care. This is done through fundamental activities that impact care (Patterson, 1991).

Previous accreditation manuals included eight nursing care standards. These were consolidated into six new nursing care standards for 1991. Patient care is the focus of the first four standards. Standard five speaks to a single nurse executive for each hospital and the participation of nursing leaders with other hospital leaders in planning and decision making. Quality assurance was the focus of standard six (Hurley, 1991). These standards went into effect January 1, 1991. Although during 1991 hospitals were not held to the requirement that they were in compliance for at least 12 months prior to survey, starting January 1, 1992 all healthcare organizations will be expected to have the 12 month compliance requirement (Hurley, 1991).

These six new nursing care standards defined by the JCAHO in the 1991 Accreditation Manual for Hospitals (AMH) are as follows:
Nursing Care (NC). 1 - "Patients receive nursing care based on a documented assessment of their needs" (JCAHO, 1990a, p. 131).
NC.2 - "All members of the nursing staff are competent to fulfill their assigned responsibilities" (JCAHO, 1990a, p. 133).
NC.3 - "The nurse executive and other appropriate registered nurses develop hospitalwide patient care programs, policies and procedures that

describe how the nursing care needs of patients or patient populations are assessed, evaluated, and met" (JCAHO, 1990a, p. 134).

NC.4 - "The hospital's plan for providing nursing care is designed to support improvement and innovation in nursing practice and is based on both the needs of the patients to be served and the hospital's mission" (JCAHO, 1990a, p. 136).

NC.5 - "The nurse executive and other nursing leaders participate with leaders from the governing body, management, medical staff and clinical areas in the hospital's decision-making structures and processes" (JCAHO, 1990a, p. 137).

NC.6 - "As part of the hospital's quality assurance program, the quality and appropriateness of the patient care provided by all members of the nursing staff are monitored and evaluated in accordance with Standard QA.3 and Required Characteristics QA .3.1 through QA .3.2.8 in the "Quality Assurance" chapter in this manual" (JCAHO, 1990a, p. 138).

Each standard is divided into numerous required characteristics.

The format for the SIR consists of the following areas:

1. Standard - The standard/required characteristic is listed by number only. The actual standard/required characteristic can be referred to in the 1991 Accreditation Manual for Hospitals (AMH) Volume 1, as needed. Standards/required characteristics are grouped by page(s) according to applicable score codes.
2. Criteria - The criteria attempt to reword the standard into familiar terms (if necessary) that can be checked by nursing staff.
3. Process - The process area describes how compliance to the required characteristics is determined. This can include review of Nursing Service Memorandums, policies, procedures and education records to ensure their accuracy and content, actual review of

medical records and documentation or interviews with patients/staff.

4. Score code - Scoring guidelines for the nursing care standards as approved by the Joint Commission's Standards and Survey Procedures Committee are used to obtain a score which is then recorded. Scoring guidelines change depending upon the standard/required characteristics being evaluated. Scoring guidelines are cited from Volume II of the 1991 AMH. The two volume format of publishing the scoring guidelines with the standards was initiated with the 1991 AMH. Volume 1 consists of the standards and volume II consists of the scoring guidelines (JCAHO, 1990a). Scoring guidelines are used to assess and report the level of compliance with the standards. Six rankings are available including the numbers 1 through 5 and NA (not applicable). The rating scale for compliance is as follows (JCAHO, 1990b):

   1 - Substantial compliance - indicates consistent compliance of the healthcare organization with all major conditions of the standard/required characteristic.

   2 - Significant compliance - indicates that the healthcare organization meets the majority of conditions of the standard/required characteristic.

   3 - Partial compliance - indicates that the healthcare organization meets some conditions of the standard/required characteristic.

   4 - Minimal compliance - indicates that only a few of the conditions of the standard/required characteristic are met by the healthcare organization.

   5 - Noncompliance - indicates the failure of the healthcare organization to meet the conditions of the standard/required characteristic.

NA - Not applicable - indicates the nonapplicability of the standard/required characteristic to the healthcare organization (JCAHO, 1990b).

5. Evidence of compliance - This area is used by the nurse reviewer to record specific comments concerning evidence of compliance (or noncompliance) to the standard.

6. Recommendation(s) to meet criteria - Scores of 3, 4, or 5 require recommendations by the reviewer to obtain compliance with nursing care standards. These recommendations are to be listed on the reverse of the page.

Criteria, Process and Score Code elements of the SIR were adapted, in part with permission, of JCAHO from: Joint Commission on Accreditation of Healthcare Organizations (1990). The new standards for nursing care (2nd ed). Chicago, Illinois: Author: Resource Book.

Note that the SIR contains scoring guidelines are for the first group of criteria only. Scoring guidelines for all standards/required characteristics can be found in Volume II of the AMH for the corresponding publication year (1990 publication for 1991 standards).

Proposed Systematic Internal Review (SIR) Program

1 Standard	2 Criteria	3 Process	4 Score
NC.1*	Patients receive nursing care based on a documented assessment of their needs.		
NC.1.1.*	A registered nurse assesses each patient's needs related to their admission.	1. Nursing Service Memorandum (NSM) _____ 2. Review of medical records reflects compliance	
NC.1.1.1*	Nursing assessment is completed within 24 hours (ICU - 8 hrs, Psych - 8 hrs) The following 3 factors should be considered: 1. The anticipated length of stay for the major patient population(s) served by the unit, area, or department. 2. The complexity of nursing care needs of the major patient population(s) served by the unit, area, or department. 3. The dynamics of the condition(s) of the major patient population(s) served.	1. NSM _____ 2. Review of medical record reflects appropriate time frame for completion of assessment.	
NC.1.1.2	Part I of the nursing assessment may be completed by nursing staff who are qualified by training to do so. Part II must be completed by RN. Written evidence is available to show that all members of the nursing staff are qualified to collect data.	1. NSM _____ 2. Review of medical record reflects compliance. 3. Review of education records of staff to determine that staff other than RNs are trained to perform assessment activities.	
NC.1.1.3*	Reassessment of patient needs are determined by the patient's condition.	1. NSM _____ 2. Review of medical record reflects time frame and nursing staff who perform assessments.	

Score Code: Score 1 - 1. Nursing policies and procedures define the time frame for completing the admission assessment process. The policies/procedures indicate that all 3 factors listed above have been considered and specify those aspects of the assessment process that may be delegated and to whom. Circumstances are defined in which a reassessment is to be completed. The policies/procedures indicate that, during development, consideration was given to the patient population(s) served and applicable law and regulation.
AND
2. 91-100% of the medical records reviewed include a registered nurse assessment of the patient's nursing care

needs, as specified in hospital policy and in accordance with NC.1.1.1
AND
3. 91-100% of the medical records reviewed indicate that when aspects of data collection have been delegated, the registered nurse evaluated, and participated in the process in order to identify the nursing diagnosis(es) and/or patient care needs
AND
4. Nursing policies/procedures on assessment and reassessment have been implemented for at least 12 months prior to survey.

Score 2 - 1. Same as Score 1.2 except 76-90% of medical records reviewed...OR
2. Same as Score 1.3 except 76-90% of medical records reviewed... OR
3. Same as Score 1.1 except with minor exceptions, nursing policies and procedures define the time frame for... OR
4. Same as Score 1.4 except implemented for 9-11 months prior to survey.

Score 3 - 1. Same as Score 1.2 except 51-75% of medical records reviewed... OR
2. Same as Score 1.3 except 51-75% of medical records reviewed... OR
3. Same as Score 1.1 except however policies do not specify those aspects of the process that may be delegated and to whom. Circumstances in which a reassessment is to be completed are not defined... OR
4. Same as Score 1.4 except implemented for 6-8 months prior to survey.

Score 4 - 1. Same as Score 1.2 except 26-50% of medical records...OR
2. Same as Score 1.3 except 26-50% of medical records...OR
3. Same as Score 3.3 and policies/procedures do not indicate that all 3 factors above have been considered...OR
4. Same as Score 1.4 except implemented for 3-5 months prior to survey.

Score 5 - 1. Same as Score 1.2 except less than 26% of medical records...OR
2. Same as Score 1.3 except less than 26% of medical records...OR
3. Nursing policies and procedures neither define the time frame for completing the admission assessment process nor define the circumstances in which a reassessment is to be completed...OR
4. Same as Score 1.4 except implemented for 2 months or less prior to survey.

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5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.1.2*	A thorough assessment of patients should consider the following 6 factors: (as appropriate) 1. Biophysical-Review of major body systems and physiological parameters. 2. Psychosocial-Support systems, fears, anxiety, mental status, coping mechanisms, habits, work history, sleep patterns, recreational activities, etc. 3. Environmental-physical environment, socioeconomic status, special equipment needs, etc. 4. Self care, including the need and ability to perform activities of daily living as appropriate. 5. Educational needs. 6. Discharge planning - need for continuing care and any needed modifications in the home environment.	1. Review of records reflects evidence of initial and ongoing assessments with documented consideration of these factors as appropriate.	
NC.1.2.1	Information obtained from the patient's significant others is included in the assessment.	1. Review of records documents that patient's significant others (as appropriate) were involved in the assessment process.	

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring Guidelines. Chicago, Illinois: Author.

5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.1.3*	Identification and documentation of patient care needs includes nursing diagnosis(es) statements, patient problem lists, patient nursing care needs lists (or similar related formats, as appropriate).	1. NSM _____ 2. Review of medical record provides evidence of appropriate documentation.	
NC.1.3.1	The patient and/or significant others are informed of and involved in the provision of nursing care as appropriate.	1. NSM _____ 2. Review of medical record reflects that patient/ significant others are informed and involved in patient's care.	
NC.1.3.2	Effective and appropriate collaboration among all involved professional disciplines is carried out. Examples include: Multidisciplinary team conference, consultations, etc. (as appropriate).	1. Review of medical record reflects documentation of interdisciplinary collaboration.	

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring Guidelines. Chicago, Illinois: Author.

5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.1.3.3*	Patient and/or significant others receive appropriate specific education from hospital staff to meet the patient's health care needs. In addressing these specific learning needs, consideration is given to at least the following 4 factors: 1. The patient's anticipated length of stay. 2. Appropriate utilization of applicable hospital and community resources. 3. The patient's/significant other's ability to comprehend & implement the provided education. 4. The nature and complexity of the patient's/significant other's learning needs with consideration given to a. infection control b. safety c. availability, as opposed to needed, resources after discharge.	1. NSM _____ 2. Documentation in medical record of nursing interventions to meet specific self care learning needs.	
NC.1.3.3.1	Appropriate referrals for patient's continuing care needs are assessed and documented. i.e. social work referral, follow-up appointments, plans for necessary home health equipment and medication, etc.	1. Interview patient and/or significant others prior to patient's discharge to ascertain adequate understanding of patient's health care needs. 2. Review of medical record for documentation of preparation for discharge including patient's continuing care needs and appropriate referrals.	

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol.II. Scoring Guidelines. Chicago, Illinois: Author.

5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.1.3.4*	The nursing process is used in documenting patient care. (SOAPIE format). At a minimum,there should be evidence that the nursing process is used in documenting the patient's care, specifically the following 6 elements.	The following elements apply for required characteristics NC.1.3.4 through NC.1.3.4.6 1. NSM _____ 2. Review of medical record to determine compliance with documentation.	
NC.1.3.4.1	The initial nursing assessment and all reassessments of the patient's condition are documented in accordance with nursing policy.		
NC.1.3.4.2	The patient's nursing diagnosis(es) and/or patient care needs are documented.		
NC.1.3.4.3	The plan of patient care including interventions identified to meet the patient's needs are documented.		
NC.1.3.4.4	The nursing care provided to the patient and/or significant other(s) is documented.		
NC.1.3.4.5	The effectiveness/outcomes of nursing interventions including the patient's responses to interventions are documented.		
NC.1.3.4.6	Discharge planning activities and the abilities of the patient and/or significant other(s) to manage ongoing care needs after discharge are documented.		

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring Guidelines. Chicago, Illinois: Author

5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.1.3.5*	There is permanent integration of nursing care data into the medical record. (Data related to patient assessments, the nursing care planned, nursing interventions and patient outcomes.)	1. NSM _____ 2. Review of medical records to determine integration of data.	
NC.1.3.5.1	The nursing care data must be identifiable and retrievable from the medical record.	1. NSM _____ 2. Review of medical records to determine identification and retrieval of the information.	

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring Guidelines. Chicago, Illinois: Author

5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.2*	All nursing staff are competent to fulfill their assigned responsibilities.	1. NSM _____ 2. Review of nursing policy and procedure to determine the system or structure of the organization's competence assessment program.	
NC.2.1*	Nursing staff members have their competence assessed as part of the initial employment and orientation process. Those nursing staff members who are required by law or regulation to possess licensure, registration, or certification actually are currently licensed, registered or certified.	1. NSM _____ 2. Review of employee files to determine initial competency assessment. 3. Review of employee files to determine currency and appropriateness of nursing staff member's licensure, registration, or certification. 4. Review of job/ position descriptions for all positions involved in the provision of nursing care.	
NC.2.1.1*	Each nursing staff member's competence is evaluated at defined intervals during their employment. Competence is maintained through a combination of educational activities and ongoing competence assessment.	1. NSM _____ 2. Review of employee files to determine if the competence assessment program has been implemented as defined in policy and procedure.	
NC.2.1.1.1*	An objective, measurable performance evaluation system is used to evaluate current competence.	1. NSM _____	
NC.2.1.1.2*	The objective measurement system of evaluating each nursing staff member's ability to carry out their duties is defined in policies and procedures. A report about the levels of competence and competence maintenance functions is given at least annually to the governing body.	1. NSM _____ 2. Review of the report to the governing board about the levels of competence and the competence maintenance function.	

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring guidelines. Chicago, Illinois: Author.

5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.2.1.2*	Nursing staff members are assigned nursing care responsibilities based upon	The following apply for required characteristics NC.2.1 through NC.2.1.2.2.2	
NC.2.1.2.1	The amount of availability of supervision needed by the staff member based on their previously assessed level of competence and current competence in relation to the nursing care needs of the patient(s).	1. NSM _____ 2. Review of the process for assigning nursing staff members to provide nursing care to patients. The written process must include consideration of the listed criteria. 3. Review of medical records to determine that the patient's status was such that member(s) of the nursing staff were competent to provide the required nursing care. 4. Review of assignment sheets, time schedules or other pertinent documentation to provide evidence that the system in place is adequate.	
NC.2.1.2.2	The complexity and dynamics of each patient's status including the complexity of the assessment required by the patient and the frequency with which the need for specific/ required nursing care activities changes including:		
NC.2.1.2.2.1	The factors that must be considered to make appropriate decisions concerning providing nursing care.		
NC.2.1.2.2.2	The type of technology used in providing nursing care The following seven elements should be considered in the process for assigning nursing staff members to provide nursing care to patients: 1. The complexity of the patient's condition and required nursing care. 2. The dynamics of the patient's status. 3. The complexity of the assessment required by the patient. 4. The type of technology employed in providing nursing care. 5. The degree of supervision required by each member of the nursing staff. 6. The availability of supervision. 7. Relevant infection control and safety issues.		

Score Code Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring Guidelines. Chicago, Illinois: Author.

5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.2.2*	Those registered nurses that determine the clinical competence of nursing staff members and make assignments for patient care responsibilities must have the clinical and managerial knowledge and experience to make these decisions in consideration of the following 3 factors: 1. Complexity of nursing care required by the patients. 2. Documented competence in at least the clinical knowledge, skills and technology ordinarily employed in the care of patients in the unit, area or department. 3. Written evidence of preparation through formal and/or continuing or inservice education programs in clinical management and leadership.	1. NSM _____ 2. Review of personnel records which indicate that those RNs with the designated responsibility for the evaluation and assignment of nursing staff members are competent to carry out their clinical and managerial responsibilities. Evidence of consideration of the corresponding 3 factors must be available.	

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring Guidelines. Chicago, Illinois: Author

5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.2.3*	Orientation for nursing staff members is based on specific job descriptions, positions or privileges. Orientation is of sufficient scope and length to assure competency and is conducted prior to the performance of nursing care activities. The orientation is based on identified individual learning needs of the nursing staff member.	1. NSM _____ 2. Review of nursing service policy that describes the scope and duration of orientation. 3. Review of nursing staff member's personnel/ education record to ensure participation in and completion of orientation.	
	Upon completion of the orientation program, an assessment of the nursing staff member's competence in their specific job activities is conducted.	1. Assessment by an RN of the individual's ability to competently perform the specific nursing care activities required.	
	Nursing staff meetings are conducted at regular intervals, determined by the organization and defined in hospital policy.	1. NSM _____ 2. Review of nursing service policy that describes the frequency of staff meetings.	
	During these meetings, findings from quality assurance activities are reviewed and opportunities to improve care and solve problems and improve skills, knowledge and abilities are discussed.	1. NSM _____ 2. Review of staff meeting minutes which evidence these activities.	
	Nursing staff members participate in both formal and informal educational activities. The education program is based on factors including: 1. Findings from quality improvement activities. 2. New or changing technology, as appropriate 3. Therapeutic or pharmacologic interventions. 4. Identified or stated learning needs of nursing staff members.	1. NSM _____ 2. Review of education/staff development records which evidence educational activities considering these factors.	

1 Standard	2 Criteria	3 Process	4 Score
NC.2.3.1*	Documentation on the content and scope of the program and the extent of the nursing staff member's participation is included in the employee's personnel/education record.	1. NSM _____ 2. Review of employee's personnel/education record.	
	Documentation of participation in nursing staff meetings is maintained.	1. Review of staff meeting minutes which evidence staff participation.	
	Documentation of participation in educational activities is documented.	1. Review of employee's personnel/education record.	

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring Guidelines.

5. Evidence of Compliance:

*The asterisked items are key factors in the accrediation decision process. Scores of 3, 4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.2.3.2*	Appropriate nursing staff must be competent in CPR and other safety issues appropriate to the mission of the hospital i.e. CPR, respiratory therapy. Policies, procedures and/or protocols define who can carry out emergency interventions and what degree of supervision is required. Exception of staff members who for physical or other specified reasons are unable to perform the required activity is acceptable.	1. NSM _____ 2. Hospital/Nursing statement that defines what safety issues, other than CPR are appropriate. 1. NSM _____ 2. Review of nursing policy/procedure defines a. which members of nursing staff are expected to demonstrate competence in CPR and other safety issues. b. exempted individuals from these requirements. c. mechanism used to demonstrate competence. d. how/where such competence will be documented.	
NC.2.3.2.1*	Competence of these nursing staff members is demonstrated and documented at least every two years.	1. NSM _____ 2. Review of records that evidence staff members' competence.	

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring Guidelines. Chicago, Illinois: Author.

5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.2.3.3*	If nursing staff members are expected/required to provide nursing care in more than one type of nursing unit, the staff member must be competent to provide patient care on each unit or to each type of patient.	1. NSM _____ 2. Review of hospital/nursing policy addressing orientation and cross training for nurses that are assigned to more than one type of nursing care unit or patient population. 3. Review of written plans, records, or reports that describe the requirements for the assignment of nursing personnel. 4. Review of the mechanism for assuring and documenting the availability of a competent RN if staff members have not been oriented or cross trained.	
NC.2.3.3.1*	Adequate orientation and cross training are provided within a reasonable period of time prior to giving that care.	1. NSM _____ 2. Review of documentation relating to cross training activities, according to hospital/nursing policy. 3. Review of personnel files from cross trained employees.	

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring Guidelines. Chicago, Illinois; Author.

5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.2.4*	If outside sources ("agency") of nursing personnel are used by the hospital, these personnel receive orientation prior to providing care.	The following process elements apply to NC.2.4 through NC.2.4.1.1.1	
NC.2.4.1*	Before these nursing personnel engage in patient care activities it is the responsibility of the hospital to assure these individuals meet the following criteria: a. Possess a current, valid license or certificate to practice nursing or perform nursing care activities as required by applicable law or regulation. b. Has documented, current clinical competence in the assigned patient care responsibilities. c. Has completed an adequate and timely orientation to the hospital/unit.	1. NSM _____ 2. Review of hospital and/or nursing policies and procedures that define the responsibilities for process of evaluating the performance of these individuals. 3. Review of contracts, written agreements, letters or memoranda of understanding that have been approved by the organization which outline who bears responsibility for documenting licensure and current clinical competence. 4. Review of agency nurse's file to determine compliance with policies and procedures.	
NC.2.4.1.1*	The performance of these outside sources of nursing personnel in the hospital is evaluated.		
NC.2.4.1.1.1*	Hospitals/nursing policy defines the responsibility for this evaluation.		

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991; Vol. II. Scoring Guidelines. Chicago, Illinois: Author.

5. Evidence of Compliance:

*The asterisked items are key factors in the accreditation decision process. Scores of 3,4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
NC.3*	Hospitalwide patient care programs, policies and procedures that describe how the nursing care needs of patients and patient populations are assessed, evaluated and met are developed by the nurse executive and appropriate RNs within the hospital.		
NC.3.1*	Nursing standards of patient care (the care the patient can expect to receive from the nursing staff) and standards of nursing practice (what the nursing staff does to meet the standard of care through nursing practice) in conjunction with nursing policies and procedures direct the nursing care delivered within the hospital. A hospital may use published standards or write their own. If published standards are used, adaptation considering the scope of care provided by the unit/hospital must be evident.	1. Review of the nursing standards for patient care and standards for nursing practice. 2. Review of minutes, reports and memoranda that contain evidence that the nursing standards were the basis for the development of nursing policies and procedures. 3. Review of nursing policies and procedures that have been developed and implemented addressing the nursing care provided to patients and those significant to them. 4. Review of patient medical records for evidence that applicable standards of patient care and nursing practice were implemented as appropriate to the patient's needs and the policies and procedures were used to guide nursing care. 5. Review of written records, minutes or reports about the level of conformance to nursing standards of patient care and standards of nursing practice used in the M&E of the quality and appropriateness of nursing care delivered.	

	Development of nursing policies and procedures should consider the following 4 items: 1. Types of patients served. 2. Scope/complexity of patient's needs for nursing care. 3. Knowledge/skill level of nursing staff members who provide care. 4. How the nursing care needs of patients will be assessed, evaluated and met.	1. Review of minutes, reports and memorandum that contain evidence that consideration was given to the 4 factors listed.	

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5. Evidence of Compliance:

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1 Standard	2 Criteria	3 Process	4 Score
QC.3.1.1*	Establishing standards of nursing practice is the authority and responsibility of the nurse executive.	1. NSM _____ 2. Review of the document that defines the authority and responsibility of the nurse executive with respect to the establishment of the nursing standards of patient care, nursing practice and policies and procedures.	
QC.3.1.2*	Policies, procedures and standards are:	1. NSM _____ 2. Review of documentation that evidencees that policies/ procedures/standards were developed by these nursing staff (and in collaboration with other disciplines as necessary) and approved by nurse executive/designee.	
QC.3.1.2.1	Developed by Nurse executives, registered nursing and other nursing staff.		
QC.3.1.2.2	Defined in writing.		
QC.3.1.2.3	Approved by nurse executive/ designee.		
QC.3.1.2.4	Used in assessing the quality of patient care.	1. NSM _____	
QC.3.1.2.5	Reviewed/modified when warranted.	1. NSM _____ 2. Review of policy that defines the process for developing, reviewing and modifying standards, policies and procedures.	
QC.3.1.2. 5.1	Reviewed as outlined in nursing policy with reviews at least every 3 years. Documentation of review activities includes the following 3 elements: 1. Review date. 2. Nursing staff members who participated in the review. 3. Identification of the selected standards, policies and/or procedures that were modified, revised and/or deleted.	1. NSM _____ 2. Review of the records, reports, minutes or the policies and procedures which evidence that the reviews were completed according to policy and these elements are included.	

NC.3.1.2. 5.2	When appropriate the review should also consider the following 4 factors: 1. The appropriateness of the policies, procedures and standards in actual use. 2. Any relevant ethical and legal concerns. 3. Current scientific knowledge. 4. Findings from quality improvement or other evaluation mechanisms are used as information	1. NSM_____ 2. Review of a quality improvement plan (when available), minutes, reports or memorandum(a) for evidence that the standards, policies and procedures were used in the process to monitor and evaluate the quality and appropriateness of the nursing care provided to patients.
NC.3.3*	Collaboration with other disciplines is necessary when developing nursing policies and procedures addressing functions that involve, impact, or influence activities beyond the unit, area or department that provides nursing care to patients.	1. As outlined above - NC.3.1.2.1 - NC.3.1.2.3

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1 Standard	2 Criteria	3 Process	4 Score
NC.3.2*	A mechanism for nurses to address ethical issues and potential dilemmas in nursing care must be in place.	1. NSM _____ 2. Review of evidence (policies, minutes), that participation by nursing staff members occurs on the ethics committee.	
NC.3.2.1*	Nursing staff members participate on the hospital ethics committee addressing ethical issues in patient care.		
NC.3.3	(Previous Page)		

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1 Standard	2 Criteria	3 Process	4 Score
NC.3.3.1*	The nurse executive or qualified designee must participate in the hospital admission system for the purpose of coordinating patient nursing care needs with available nursing resources.	1. NSM _____ 2. Review of the document that defines the authority and responsibility of the nurse executive or designee to participate in the hospital admission system.	
NC.3.3.1.1	Consideration of the patient's requirements for nursing care and available nursing resources is essential when making a decision regarding when or where to admit or to transfer a patient.	1. NSM _____ 2. Review of records, report assignment sheets or other documents that indicate that sufficient, competent nursing staff members were available to assess and meet the nursing care needs of the patient admitted or transferred to a unit, area or department.	

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1 Standard	2 Criteria	3 Process	Score
NC.3.4*	The mechanisms used to assign the members of the nursing staff to meet patient care needs are defined in policies and procedures. These mechanisms should address the following 3 criteria, which are approved by the nurse executive: 1. Requirements for employment as a nursing staff member. 2. The process used and elements considered when assigning patient care responsibilities to a nursing staff member. 3. The mechanism for determining the deployment of nursing staff among units/areas - such deployment includes consideration of: a. onging identification of patient's nursing care needs defined by a valid and reliable system. b. The number and mix of nursing staff required to meet patient's needs. c. The mode of nursing care delivery (i.e. primary, team etc.). d. The number of qualified registered nurses required to deliver nursing care to those who require a specific level of care; to coordinate the care of patients and to supervise and direct nursing care provided to patients by other nursing staff members.	1. NSM _____ 2. Review of job descriptions and nursing/hospital policies and procedures that define the mechanisms used to assign nursing staff members to meet patient care needs.	
NC.3.4.1*	There are sufficient qualified nursing personnel available to meet the nursing care needs of the patients throughout the hospital.	1. NSM _____ 2. Review of staffing plans and other related reports which indicate that sufficient nursing staff members were available to meet the patient's defined nursing care needs. 3. Review of 3 one week schedules over the past 12 months to determine if the hospital has met its	

		established requirements for nursing staff.	
NC.3.4.1.1	The nurse executive approves the criteria for employment, deplcyment, and assignment of nursing staff members.	1. NSM _____ 2. Review of reports, minutes, memoranda, policies and procedures that document the nurse executive's approval of the above criteria.	

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1 Standard	2 Criteria	3 Process	4 Score
NC.3.4.2*	Nurse staffing plans for each unit must exist which define the members and mix of nursing personnel based on current patient care needs.	1. NSM _____ 2. Documentation of master staffing plan or acuity system to show what determines need/mix.	
NC.3.4.2.1	Nurse staffing plans appropriately consider the utilization of various levels of nursing personnel (RNs, LPNs, NAs) in their contribution to the delivery of efficient and effective patient care. This plan must address these 4 components: 1. The system that is used for assessing current patient nursing care requirements has face validity and interrater reliability. 2. The number, mix and qualifications of nursing personnel required to meet the identified patients' nursing care needs are stated in numbers of persons, FTEs, nursing care hours or another comparable method. 3. Consideration of the utilization of all levels of nursing staff as determined by the patients' nursing care needs and the defined scope of practice for each category of nursing staff members. 4. The process for at least annual evaluation of the plan's efficacy and efficiency in providing nursing care to patients.	1. Review of the written, formal plan for nurse staffing. 2. Review of system that is utilized for assessing patients nursing care requirements - evidence of how face validity is determined. - mechanism that is used to assure interrater reliability. 3. Review of staffing schedules. 4. Defined mechanism for annual review and results of most current annual review.	

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1 Standard	2 Criteria	3 Process	4 Score
NC.3.4.2.2	Review and adjustment of the hospital's nursing staffing schedules takes place in order to meet defined patient needs or unusual circumstances.	1. NSM _____ 2. Review of the plan(s) for nurse staffing, policies/ procedures or memorandum(a) that describes the process for reviewing and adjusting (as appropriate) staffing schedules to meet defined patient needs and unusual occurrences. 3. Review of schedules, reports or other documents which contain evidence of the required review.	

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1 Standard	2 Criteria	3 Process	4 Score
NC.3.4.2.3	Members of the nursing staff have sufficient time to provide nursing care to patients as determined by QI M&E activities. Note: In the event that there are reported instances in which patient care was compromised because members of the nursing staff were required to spend time on support functions, the hospital must examine the patient support services and determine if they are sufficient. Appropriate action to permit members of the nursing staff to provide nursing care must be taken.	1. Review of QI M&E activities (if any) that examine this issue. 2. Review of the hospital's plan addressing the commitment of resources required to address this issue if an opportunity to improve the care was identified. 3. Review of patient's medical record for evidence that patient's nursing care needs are being met.	

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1 Standard	2 Criteria	3 Process	4 Score
NC.3.4.2.4	Nursing staffing levels/plans should support the participation of nursing staff members on committees, in meetings, and in quality improvement and educational activities as assigned.	1. NSM _____ 2. Review of committee/meeting minutes for evidence that nursing members, as assigned, regularly participate.	

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1 Standard	2 Criteria	3 Process	Score
NC.4*	The hospital plan for providing nursing care: 1. Is designed to support improved nursing practice through innovation and resource allocation. 2. Considers the unique needs of the patient population served by the hospital. 3. Is based upon the hospital's mission statement.	1. NSM _____ 2. Review of hospital's written plan of the provision of nursing care.	
NC. 4.1*	The plan for nurse staffing and the provision of nursing care is reviewed annually in detail and periodically as determined by changing patient needs/outcomes. Review of the plan should indicate at least the following 3 elements were considered: 1. Patient requirements for nursing care, upon which the plan for nurse staffing was based. 2. Patient care programs or patient populations that were added or eliminated and resultant changes in case mix. 3. Information, as available, regarding the nurse staffing plan, from surveys of patients and their significant other(s), physicians and other care providers, and nursing staff members.	1. NSM _____ 2. Review of minutes, reports, memoranda which evidence documentation of annual review of the hospital's plan for nursing care.	

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1 Standard	2 Criteria	3 Process	4 Score
NC.4.1.1*	A sufficient number of registered nurses must be available to prescribe, delegate, and coordinate nursing care throughout the hospital. The nurse staffing plan provides for a sufficient number of registered nurses to carry out at least the following 3 activities: 1. Prescription of nursing care for patients based on a. Assessment data and other relevant information. b. Identified nursing diagnoses, needs, problems. c. Appropriate nursing interventions. d. Patient's response to nursing interventions. 2. Delegation of nursing activities to appropriate nursing staff members and the registered nurse's evaluation of the staff members qualifications and competence to safely/effectively carry out the delegated responsibilities and to provide timely and adequate supervision as required. 3. Coordination of both the nursing care provided to patients and the nursing care provided in conjunction with therapies directed by other disciplines.	1. NSM _____ 2. Review of documentation that identifies those areas in the hospital where nursing care is provided to patients and patient populations served in those areas.	

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1 Standard	2 Criteria	3 Process	4 Score
NC.4.1.2*	The established nursing standards of patient care and nursing practice are used in the monitoring and evaluation process of the nursing department, service or area. The outcomes of this process should demonstrate that the same level of nursing care was provided to patients with the same nursing care needs in the hospital.	1. NSM _____ 2. Review of the nursing standards of care to assure that comparable patient populations have received the same level of care. 3. Review of minutes, reports, or the hospital's quality assurance plan that evidence the process used to identify important aspects of care and indicator selection.	

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1 Standard	2 Criteria	3 Process	4 Score
NC.4.2*	The hospital's budget review process includes review of the appropriateness of the hospital's plan for providing nursing care to meet patient needs.	The following apply for required characteristics NC.4.1, NC.4.1.1 and NC.4.2 through NC.4.2.2.1	
NC.4.2.1	This review includes:	1. NSM _____ 2. Review of documentation which demonstrates that the hospital's plan for the provision of nursing care was considered as part of the budget review process. 3. Review of job descriptions, policies, procedures, privileges, contracts, etc. which identify RN responsibility and accountability for nursing care.	
NC.4.2.1.1	Actual staffing patterns analysis with special attention to patterns or trends.		
NC.4.2.1.2	Information from quality assurance risk management, utilization review and other hospitalwide activities that relate to the plan for nursing staffing.		
NC.4.2.2	Resource allocation (financial and other) is reviewed to determine the appropriateness, efficiency and effectiveness of the nursing care provided.		
NC.4.2.2.1	The allocation of financial and other resources is designed to allow the nursing staff to pursue activities designed to promote innovation and/or improvement in the provision of nursing care. Documentation indicates that as part of the budget review process, as outlined in the hospital's budget calendar, the following 6 factors are included: 1. Identified patient requirements for nursing care and the effectiveness of the hospital's plan for nurse staffing. 2. The hospital's ability to attract and retain the numbers and types of nursing personnel required in the nurse staffing plan. 3. Data from ongoing staffing variance reports that indicate the plan's adequacy/inadequacy to meet patient requirements for nursing care, with special attention to patterns or trends. 4. Information from quality assurance, risk management, utilization review and other activities that relate to the		

	nurse staffing plan. 5. Whether the nursing care delivered to patients with the same nursing care needs is directed by defined nursing standards of patient care and standards of nursing practice that are consistent between units, areas, or departments of the hospital. 6. The nursing staff ability to pursue activities designed to promote innovation and/or improvement in the provision of nursing care.		

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1 tandard	2 Criteria	3 Process	4 Score
:.5*	The nurse executive and other nursing leaders participate with leaders from the governing body, management, medical staff and other clinical areas in the hospital decision-making structures and processes. The nurse executive has the authority to assure the following four functions are addressed: 1. Participation in developing hospitalwide patient care programs, policies and procedures describing how the nursing care needs of patients/ patient populations receiving nursing care are assessed, evaluated and met. 2. Participation in developing and implementing the hospital's plan for provision of nursing care. 3. Participation with other governance, managerial, and medical staff and other clinical leaders in the decision-making structures and processes of the hospital. 4. Responsibility for the implementation of an effective and ongoing program to monitor, evaluate, and improve the quality and appropriateness of nursing care delivered to patients of the hospital.	1. NSM _____ 2. Review of the contract, job/position description, agreement of memorandum(a) which documents that the nurse executive has the authority to assure that these four functions are addressed.	
:.5.1*	Nursing services are directed by a nurse executive who is a registered nurse qualified by advanced education and management experience (knowledge and skills normally associated with master's degree). - Nursing executive must hold current licensure. Factors to be considered in the appointment of the nurse executive include: 1. Educational requirements of position. 2. Scope and complexity of organization and scope of authority and responsibility. 3. Scope and complexity of nursing care needs of the patients served by the hospital. 4. Educational/experiential requirements for leadership	1. NSM _____ 2. Review of the contract, job/position description, agreement or memorandum(a) that evidences that these six factors were considered in the appointment of the nurse executive.	

	peers. 5. Availability of nursing support staff and services. 6. Applicable federal, state and local laws/regulations that impact on the academic or experiential requirements.		

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1 Standard	2 Criteria	3 Process	4 Score
NC.5.1.1*	In the event that a hospital uses a decentralized organizational model, there is a designated nurse leader at the executive level. The nurse executive has the authority to assure the following four functions are addressed: 1. Participation in developing hospitalwide patient care and programs, policies and procedures describing how the nursing care needs of patients/patient populations receiving nursing care are assessed, evaluated and met. 2. Participation in developing and implementing the hospital's plan for provision of nursing care. 3. Participation with other governance, managerial, and medical staff and other clinical leaders in the decision-making structures and processes of the hospital. 4. Responsibility for the implementation of an effective and ongoing program to monitor evaluate, and improve the quality and appropriateness of nursing care delivered to patients of the hospital. Factors to be considered in the appointment of the nurse executive include: 1. Educational requirements of position. 2. Scope and complexity of organization and scope of authority and responsibility. 3. Scope and complexity of nursing care needs of the patients served by the hospital. 4. Educational/experiential requirements for leadership peers. 5. Availability of nursing support staff and services. 6. Applicable federal, state and local laws/regulations that impact on the academic or experiential requirements.	1. NSM _____ 2. Review of hospital organizational structure/plan to determine if all clinical and managerial activities are functionally or structurally decentralized. 3. Review of bylaws, articles, policies and procedures or minutes for documentation of the defined mechanism and evidence that the four factors were considered in the appointment of the appropriately prepared registered nurses. 4. Review of reports or minutes from defined or established meetings of the hospital leadership for evidence of one appropriately prepared registered nurse speaking on behalf of nursing and that this individual has a voice at these forums.	

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1 Standard	2 Criteria	3 Process	4 Score
IC.5.1.2*	If the organization is part of a multi-hospital system, the nurse executive must participate at the system's corporate level when policy decisions are made that affect patient care services. The mechanism employed by the system to accomplish this is system specific. 3 elements must be addressed regarding this mechanism. 1. The scope and degree of involvement including the authority and responsibility of the nurse executive in policy decisions that affect patient care services.	1. NSM _____ (or Hospital Policy). 2. Review of the hospital's system's organizational plan, contract, written agreement or job description, that describes or defines the authority and responsibility of the nurse executive.	
IC.5.1.2.1	2. The means to be used to include information generated from such participation in activities and other mechanisms designed to improve the nursing care provided to patients in the hospital; and 3. The process for resolving conflicts in opinion when the nurse executives demonstrates that policy decisions could potentially negatively affect patient care services.	1. NSM _____ (or Hospital Policy). 2. Review of letters, memoranda, minutes or reports that outline the mechanism used by the multi-hospital system that evidences participation in corporate level policy decisions that affect patient care services.	
IC.5.1.2.2	The mechanism(s) is/are defined in writing.	1. NSM _____ (or Hospital Policy).	

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1 Standard	2 Criteria	3 Process	4 Score
NC.5.2* and NC.5.2.2*	The nurse executive (or a designee) must have a voice when decisions are made or reviewed that influence the provision of care to patients. The nurse executive participates in meetings forums or other activities where discussion or action focuses on the development or review of the following 5 elements: 1. the hospital mission 2. strategic plans 3. the budget and resource allocation 4. operational plans 5. policies	1. Hospital Policy_____ 2. Review of minutes, reports or memoranda that document the scope and degree of involvement of the nurse executive in the development of the nursing budget.	

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NC.5.2.1*	The nurse executive, assisted by other nursing leaders and hospital personnel, develops a budget for each nursing unit, area, or department. The following 6 factors should be considered when developing the nursing budget: 1. The assumptions upon which the nursing budget is built (i.e. projections concerning opening a new unit or closing beds). 2. The establishment of a budget calendar for the preparation and presentation for approval of the nursing budget. 3. Which nursing leaders are involved, and their level of involvement. 4. Use of applicable data and information from the ongoing review of the system is used to address the adequacy of the allocation of fiscal resources for the provision of nursing care to patients, (i.e. staffing variance for previous year, risk management and QA/QI results, census data reports). 5. Use of applicable information from the hospital's strategic planning process that indicates any need to refine the fiscal resources allocated for providing nursing care. 6. The process that will be used to monitor the performance of the unit/area/department in relationship to the approved budget including the methods of monitoring and acting upon identified defined variance.	1. Hospital Policy _____ 2. Review of the nursing budget, budget calendar, reports, minutes or other appropriate records for evidence that the six factors discussed in the intent statements were considered.

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1 tandard	2 Criteria	3 Process	4 Score
C.5.3*	Nursing leaders participate with other hospital leaders in planning, promoting and conducting hospital-wide quality monitoring and improvement activities.	1. Hospital Policy _____ NSM _____ 2. Review of the QI/QA plan and other plans/reports/ memoranda for evidence of a defined mechanism for the nurse executive and other nursing leaders to participate and interact with other hospital leaders in activities designed to promote or improve the quality of patient care.	

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IC.5.3.1*	Registered nurses evaluate nursing practice to improve the quality, appropriateness and efficiency of patient care.	1. NSM _____ 2. Review of the hospital's QA/QI plan for a description of the role and function of the nurse executive and other nursing leaders in assuring that the plan is implemented and that information is acted upon.

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. Evidence of Compliance:

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:.5.3.2*	The nurse executive must actively participate in the development and implementation of the mechanisms that support, foster and encourage collaboration between and among the members of the interdisciplinary health care team.	1. NSM _____ Hospital Policy _____ 2. Review of minutes, plans, reports or documentation in medical records, when appropriate, for evidence of the use of the collaborative, inter-disciplinary process for the planning, delivery and the monitoring and evaluation of patient care.

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1 Standard	2 Criteria	3 Process	4 Score
NC.5.4*	The nurse executive and other nursing leaders are responsible for the development, implementation and evaluation of programs which promote the recruitment, retention, development and continuing education of nursing staff members. The following 6 factors need to be considered by the nurse executive and other nursing leaders in developing programs that promote the recruitment, retention, development and continuing education of nursing staff members: 1. The hospital's mission. 2. The case mix of patients served by the hospital and the degree and complexity of nursing care required by these patients and their significant other(s). 3. The technology employed in the care of patients. 4. The expectations of the hospital, medical staff and patients and their significant other(s) for the type and degree of nursing care provided. 5. The stated, felt, or otherwise identified learning needs of nursing staff members. 6. Those issues identified or stated by nursing staff members that influence their decision to continue employment with the hospital.	Compliance to required characteristics NC.5.4 through NC.5.4.2 determined by: 1. NSM _____ Hospital Policy_____ or Program title _____ 2. Review of documents that evidence at least one program was developed to promote these activities. 3. Review of written plans, minutes or reports that document consideration of the six factors listed in the development, implementation and evaluation of the program(s). 4. Review of a plan or report that outlines the method(s) for promoting the educational and advancement goals of the nursing staff. 5. Review of records, reports or minutes for evidence that the mechanism was developed by the nurse executive in collaboration with hospital leadership and that the plan was implemented.	
NC.5.4.1	The nurse executive and other nursing leaders participate in developing and implementing mechanisms which recognize the expertise and performance of nursing staff members involved in patient care.		

:.5.4.2	The nurse executive, in collaboration with other hospital/ nursing leaders develop and implement mechanisms for promoting the educational and advancement goals of staff members.		

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1 Standard	2 Criteria	3 Process	Score
IC.5.5*	The nurse executive (or designee) is responsible for improving the quality of the products or services of the staff and implementing methods that increase their efficiency and productivity while supporting patient care needs.	1. NSM _____ Hospital Policy _____ 2. Review of contracts, reports, records, or minutes that evidence the nurse executive's participation in the listed activities.	
IC.5.5.1	The use of efficient interactive information management systems for nursing, other clinical, and nonclinical information is facilitated whenever appropriate. The nurse executive must participate in the following: 1. Evaluation of health care technology and/or information management systems. 2. Selection of health care technology and/or information management systems based on such evaluation. 3. Integration of health care technology and/or information management systems in nursing care units, areas or departments.		

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring Guidelines. Chicago, Illinois: Author.

. Evidence of Compliance:

The asterisked items are key factors in the accreditation decision process. Scores of 3, 4 or 5 require recommendations to meet criteria on reverse.

1 Standard	2 Criteria	3 Process	4 Score
2.5.6*	Collaboration/communication between appropriate nurse leaders and nurse educators must be established when a hospital provides clinical facilities for nursing education programs. Evidence of this collaboration/ communication could be evidenced by one or more of these activities: 1. Joint appointments between the hospital and school of nursing or qualified registered nurses who meet academic and experience requirements. 2. Routine, scheduled meetings between hospital nursing staff members and the school of nursing faculty with documented collaboration. 3. At least one annual meeting is held between the dean/ director, or a designee of the education program or school of nursing and the nurse executive, or a designee in which they discuss the clinical and/or managerial learning experiences available to students and any opportunities to improve the nursing care provided to patients that has been identified by the faculty.	1. NSM _____ and/or Hospital Policy _____ 2. Review of contracts with nursing schools, records, reports, minutes or memoranda for evidence of this collaboration.	

Score Code: Scoring guidelines for these standards/required characteristics may be found under Nursing Care in:
Joint Commission on Accreditation of Healthcare Organizations (1990). Accreditation manual for hospitals, 1991: Vol. II. Scoring Guidelines. Chicago, Illinois: Author.

. Evidence of Compliance:

The asterisked items are key factors in the accreditation decision process. Scores of 3, 4 or 5 require recommendations to meet criteria on reverse.

1 andard	2 Criteria	3 Process	4 Score
.6*	As part of the hospital's quality assurance program, the quality and appropriateness of patient care provided by all members of the nursing staff are monitored and evaluated in accordance with Standard QA.3 and Required Characteristics QA.3.1 through QA.3.2.8. Your plan (if available) should reflect an ongoing, planned, systematic, monitoring process. A scope of service statement should be provided. Identified patient groups served by service/ unit/division should be shown.	Compliance with NC.6 and its Required Characteristics and Standard QA.3 and its Required Characteristics determined by: 1. Review of written plan, notes or minutes that: a. Describes the monitoring and evaluation activities including the department, area or service. b. Evidence the implementation and ongoing monitoring and evaluation activities. c. Evidence that actions are taken when opportunities for improvement or problems are identified. 2. Review of reports that document the findings and conclusions pertaining to the quality and appropriateness of nursing care. 3. NSM _____ and/or Hospital Policy _____	
.6.1*	The nurse executive is responsible for implementing the monitoring and evaluation process.	1. NSM _____ 2. There is evidence of the nurse executive's responsibility.	
.6.1.1*	Nursing staff members participate in:	1. NSM _____ 2. Evidence of nursing staff members participation.	
.6.1.1.1	The identification of the important aspects of care for each patient care unit (high volume, high risk or problem prone areas).	1. NSM _____ 2. At least 2 important aspects of care for patient population groups served should be identified.	
.6.1.1.2	The identification of the indicators used to monitor the quality and appropriateness of the important aspects of care and	1. NSM _____ 2. At least 2 indicators for important aspects of care.	
.6.1.1.3	The evaluation of the quality and appropriateness of care.		

.6.2*	When an outside source(s) provides nursing services,the nurse executive or the chief executive officer in the absence of the nurse executive is responsible for implementing the monitoring and evaluation process.	1. NSM _____ and/or Hospital Policy _____ 2. Evidence of nurse executive's or CEO's responsibility.

)re Code: The scoring of these standards is determined by assessing the standards that address the process for monitoring and evaluating the quality and appropriateness of patient care.

Evidence of Compliance:

ıe asterisked items are key factors in the accreditation decision process. Scores 3, 4 or 5 require recommendations to meet criteria on reverse.

1992 Revision of 1991 Nursing Care Standards

Of significant importance is the deletion of NC.6 (Quality Assurance) in the 1992 AMH publication. Therefore the 1992 AMH includes five NC standards. Those Nursing Care standards concerned with M&E were moved from the "Nursing Care" chapter to the "Quality Assessment and Improvement" chapter of the 1992 accreditation manual (JCAHO, 1991a). M&E will be discussed next in this chapter. In keeping with the Agenda for Change initiatives, the 1992 Accreditation Manual for Hospitals has renamed the "Quality Assurance" chapter "Quality Assessment and Improvement" and includes revisions and additions to the 1991 standards (JCAHO, 1991a). The five remaining NC standards have little if any revisions from the 1991 to the 1992 AMH editions and thus the SIR can still be used with minimal revisions for its intended purpose for these five standards. However, Nursing Service will need to develop a self assessment program to assure compliance with any applicable 1992 standards from the "Quality Assessment and Improvement" chapter (as well as other standards throughout the AMH).

Monitoring and Evaluation (M&E) Process

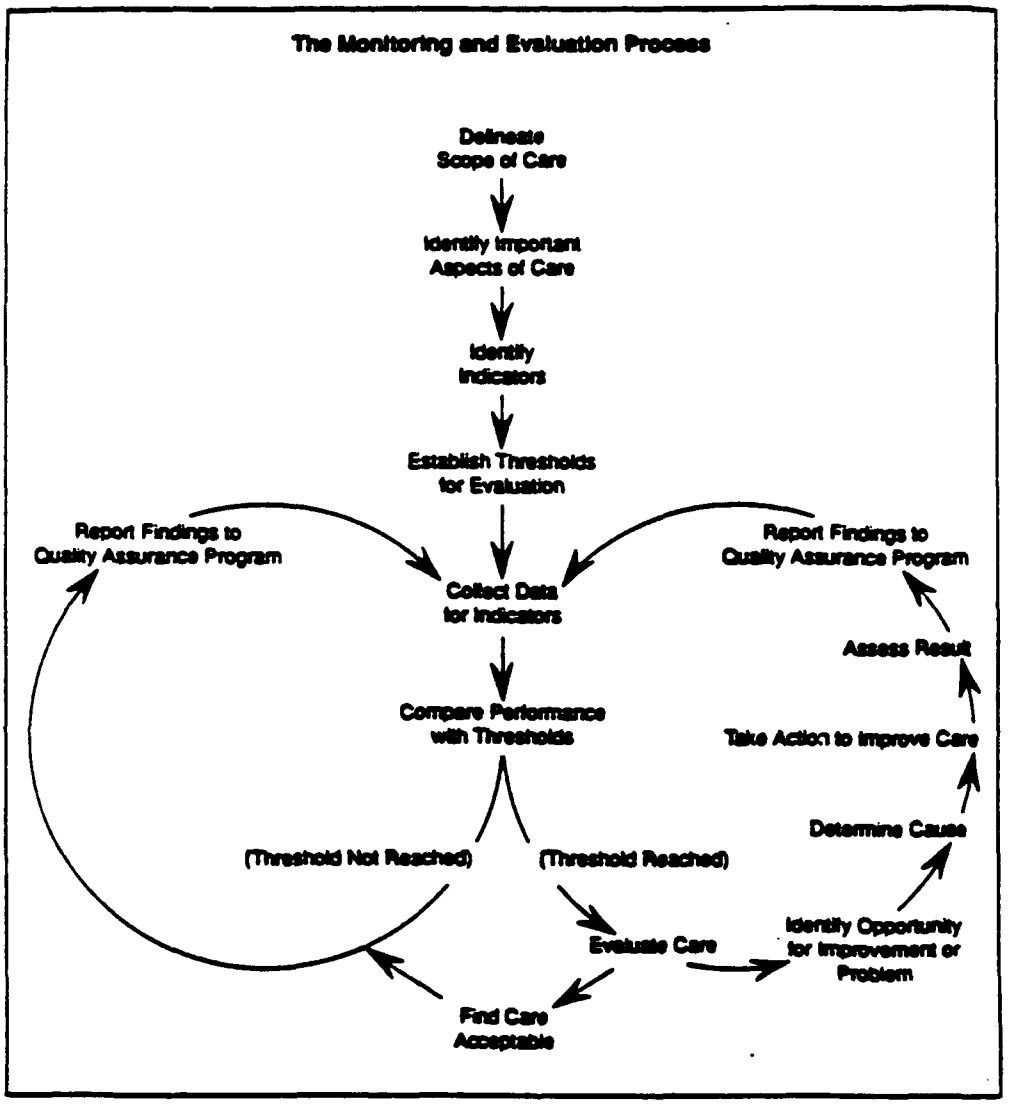
The majority of quality assurance activities mandated by the JCAHO are performed using the monitoring and evaluation process. The 1992 AMH still requires the quality of patient care in all patient care services to be monitored and evaluated. According to JCAHO (1991a), the intent of revising the M&E standards is to help hospitals overcome the following weaknesses of current QA practice:

- frequently focusing on the clinical aspects of care instead of the interrelated processes (governance, management, support and clinical) affecting patient outcomes;
- frequently separating QA activities into departments or disciplines instead of having the flow of patient care determine the organization of QI activities, which may often involve interrelated processes among different departments and disciplines;
- frequently focusing on individual performance, mainly on problem performance, instead of on how well processes are performed, integrated and coordinated and ways the processes can be improved;
- frequently taking action only if a problem is identified instead of looking for better ways to perform processes; and
- separating the appropriateness ("was the right thing done?") and the effectiveness ("Was it done right?") of care from the efficiency of care, rather than integrating efforts to improve patient outcomes with those to improve efficiency (that is, improving value) (JCAHO, 1991a, p. 138).

The intent of revising the M&E standards is to change the focus of quality assessment and improvement activities away from a specific discipline or departmental approach, and away from a focus of direct care and problem and individual orientation (JCAHO, 1991a). Rather the revised approach is intended to reflect the following principles:

- Patient care quality can be improved by assessing and improving processes affecting patient outcomes. Governance, clinical, managerial and support processes should be considered.
- Some processes are carried out by members of governance, management, clinical areas, or support areas while some processes are performed jointly by one or more groups.
- Irregardless of who performs the process, the processes need to be coordinated and integrated with attention from hospital leadership.
- A hospital's primary goal should be to assist everyone in improving the processes in which they are involved. The majority of staff (governance, managerial, clinical and support) are competent and motivated to perform the processes. More frequent than errors and mistakes are the opportunities for improving processes. Improving processes equates to improving patient outcomes (JCAHO, 1991a).

Noteworthy is the deletion of the words "and appropriateness" from the phrase "monitoring and evaluation of the quality and appropriateness of care" by the 1992 AMH manual. This is because appropriateness is considered a characteristic of quality (JCAHO, 1991a).



Visual representation of the monitoring and evaluation process as it functions from Steps 2 through 10. Appropriate staff members delineate scope of care, identify important aspects of care, identify indicators, and establish thresholds for evaluation to facilitate monitoring and evaluation of care provided in a particular department or service. Data pertaining to the indicators are collected, and the aggregate level of performance is compared with the threshold for evaluation. If the threshold is not reached, further evaluation is not necessary. These findings are included in the regular report to the organizationwide quality assurance program. When the threshold is reached, the important aspect of care is evaluated to determine whether a problem or opportunity for improvement is present. If a problem or opportunity for improvement is identified, the cause is determined and action is taken. After a sufficient period of time, the effectiveness of the actions is assessed and the findings are reported to the organizationwide quality assurance program. Monitoring and evaluation is continued to identify any future deficiencies in care.

Figure 3-1. The Monitoring and Evaluation Process

Adapted from: Joint Commission on Accreditation of Healthcare Organizations (1990). The new standards for nursing care (2nd ed). (Chapter Three: Section Six, page 21). Chicago, Illinois: Author. Resource Book.

The concept of M&E was first introduced in the 1985 AMH (Parsek, 1989). The intent of the M&E process is to help health care organizations focus on high priority quality of care issues and thus use their quality assurance resources effectively (JCAHO, 1990a). Quality assurance/improvement issues can be identified, addressed, and resolved through utilizing the M&E process (Tonges, Bradley & Brett, 1990). The intent of the CQI M&E process is to assess and improve care on an ongoing basis (JCAHO, 1991b). The current M&E process involves the following ten steps:

1. Assign Responsibility.
2. Delineate Scope of Care.
3. Identify Important Aspects of Care.
4. Identify Indicators.
5. Establish Thresholds for Evaluation.
6. Collect and Organize Data.
7. Evaluate Care.
8. Take Actions to Improve Care/Services.
9. Assess Actions and Document Improvement.
10. Communicate Information to the QA Program (JCAHO, 1990c).

Each step will now be discussed with distinctions made between current M&E practice and the M&E process within the context of Continuous Quality Improvement (CQI). Although not currently required for accreditation purposes, the CQI approach to M&E is not inconsistent with current standards. These CQI suggestions are progressing toward future standards. By implementing these suggestions, healthcare organizations will be monitoring and evaluating services and care within the context of CQI (JCAHO, 1991b). Figure 3-1 depicts the Joint Commission's current monitoring and evaluation process.

Step 1: Assign Responsibility

Current: Overall responsibility for M&E is assigned to the department's chairperson or director. For the nursing department, this individual would be the nurse administrator. The nurse administrator designates the responsibility for the specific M&E duties. A surveyor for the Joint Commission expects to see the nurse administrator actively participating in M&E activities (Parsek, 1989). Each department is responsible for overseeing and implementing M&E activities within their department (JCAHO, 1991b).

CQI: The leaders of the organization participate in and are responsible for planning and promoting the continuous improvement of quality. This includes setting priorities for assessment and improvement and involves interdepartmental as well as intradepartmental activities (JCAHO, 1991b).

Step 2: Current: Delineate the Scope of Care Provided by the Organization

CQI: Delineate Scope of Care and Service

Current: The types of patients served, conditions/diagnoses treated, clinical activities performed, types of practitioners providing care, location for the provision of care and the time when care is provided are addressed in the scope of care. Answering the question "What do we do in this department/on this unit?" is helpful in describing one's scope of care (JCAHO, 1990c). The scope of care provides a basis for the identification of those aspects of care that will be central to M&E (Parsek, 1989). Each department or service as well as each unit delineates its separate scope of care (JCAHO, 1991b).

CQI: Functions, procedures, treatments and/or other activities performed in the organization are identified. Either as a whole, or by department or service, the organization delineates their scope of care and service (JCAHO, 1991b).

Step 3: Current: Identify the Most Important Aspects of Care.

CQI: Identify the Most Important Aspects of Care and Service.

Current: This refers to the most important things/activities done by a department/unit. The aspects of care identified should be those having the greatest impact on the quality of patient care. Important aspects of care are those aspects considered to be high risk, high volume and/or problem prone (Parsek, 1989). High risk implies that patients are deprived of considerable benefits or are placed at risk of serious consequences if care is not provided correctly. High volume aspects of care affect many patients or occur frequently. Problem prone aspects of care have proven in the past to be problematic for patients or staff (Parsek, 1989). Each department or service identifies their aspects of care.

CQI: The organization chooses and prioritizes, as a whole or departmentally, those aspects of care or service that will be monitored (JCAHO, 1991b).

Step 4: Identify Indicators

Current: Each department or service identifies indicators which correspond to the aspects of care. An indicator is a measurable variable concerned with the structure, process or outcome of care (Tonges, Bradley & Brett, 1990). Structures such as equipment, resources and qualifications/numbers of staff are elements that facilitate care. Structure indicators do not refer to the actual provision of care but rather they help determine whether an organization has the capabilities to provide high quality care. The charge nurse being a qualified registered nurse is an example of a structure indicator (JCAHO, 1990c).

Indicators concerned with the process of care are process indicators. These often are based on standards of care or practice.

All patients being triaged by a registered nurse upon arrival to the emergency room is an example of a process indicator.

Outcome indicators relate to the outcome of care and are derived from literature and authoritative sources and are approved by the department. An example of an outcome indicator is the rate of complications experienced within 24 hours post invasive procedures.

CQI: Structure indicators are no longer emphasized. Indicators are developed by teams of experts from within or outside of the department. Indicators are used to measure performance of the important aspects of care (JCAHO, 1991b).

Step 5: Establish Thresholds for Evaluation.

Current: A threshold for evaluation is a preestablished expected level of performance for every indicator which is established by each department or service. Thresholds are essentially expectations of what constitutes quality care and the desired level of performance (Tonges, Bradley & Brett, 1990). They can be derived from clinical and quality assurance literature as well as the experiences of the department. Intensive evaluation of the quality and appropriateness of care is triggered when the threshold is reached to conclude if there is an actual problem and/or an opportunity to improve care. For example, for an indicator related to the completion of a nursing assessment on all inpatients, the threshold for evaluation might be set at 90%. Therefore, evaluation of the quality and appropriateness of this aspect of care would be initiated if this indicator is not done for more than ten percent of such patients.

CQI: Levels, patterns, or trends in data requiring intensive evaluation are established for each indicator by teams of experts. Regardless of the form of the threshold, it is a way to determine if resources must be invested into intensive evaluation. There are other ways to trigger

evaluation besides thresholds. Feedback from staff, patients or other sources may initiate evaluation (JCAHO, 1991b).

Step 6: Collect and Organize Data.

Current: The sources of data, the data collection method, sampling appropriateness and the frequency of data collection is established prior to the collection and organization of data (JCAHO, 1990c). Data collection should be the responsibility of all nursing personnel. Data is compared to the thresholds for evaluation. The method of data collection is determined by the department or organization (JCAHO, 1991b).

CQI: Information from sources outside of the ongoing monitoring activities is used to identify areas requiring evaluation and improvement. This information may include, but is not limited to feedback from staff, patients and their families and other people affiliated with the organization. Feedback may take the form of complaints, comments, suggestions and/or surveys (JCAHO, 1991b).

Step 7: Current: Evaluate Care

CQI: Initiate Evaluation

Current: Cumulative data are analyzed and when a threshold for evaluation is reached, qualified staff members determine if a problem exists and identify if any opportunities exist for improving care. Patterns or trends should be included in the data analysis. For example, perhaps the majority of patients falls or medication errors occurred on a certain shift. Peer review may be undertaken to conduct a review of the appropriateness of care provided by an individual practitioner. The only intense evaluation of care occurs when reaching the threshold for a specific indicator (JCAHO, 1991b).

CQI: Findings from ongoing monitoring activities that have reached threshold and feedback such as that mentioned in step 6 should be assessed as this indicates possible improvement opportunities.

Priorities are set after considering organizational resources and the potential effects on patient care/service. Teams made up of individuals knowledgeable of the aspect of care/service and representing appropriate departments are convened to evaluate the aspect of care/service. Evaluation is used to determine if opportunities exist to improve care/service. Peer review may be necessary. Opportunities for improving the quality of care/service usually exist within improving the ongoing processes of systems, equipment and personnel rather than in isolated individuals and the errors they make. This is the continuous improvement of performance (JCAHO, 1991b).

Step 8: Current: Take Actions to Solve Problems

CQI: Take Actions to Improve Care

Current: Evaluation of care may show that the provided care is/was acceptable, in which case the M&E process should continue and be reevaluated periodically to determine if it is needed to assess the quality and appropriateness of the important aspects of care. However, if problems are identified and/or opportunities for improvement are found, corrective action should be identified and planned. Identification of the problem's cause and possible solutions must be addressed. For example, the cause may be a lack of knowledge and a possible solution may be additional reference sources or educational activities (JCAHO, 1990c). In this case,personnel with authority outside of or within the department take action determined by an evaluator's recommendations (JCAHO, 1991b).

CQI: Appropriate actions are determined by the team evaluating the aspect of care/service. Teams may take the recommended actions themselves, with results forwarded to leaders. Actions are emphasized that focus on processes between departments. These actions may relate to problems with systems (staffing, communication channels, organizational structure, etc.), knowledge (circulation of information,

in-service and continuing education, accessibility of data/reports, etc.) and behavior (counseling, assignment changes, disciplinary action) (JCAHO, 1991b).

Step 9: Current: Assess Actions and Document Improvement

CQI: Assess the Effectiveness of Actions and Maintain the Gain

Current: Effectiveness of corrective actions must be assessed and documented. This can be accomplished through further M&E activities. If the level of performance improves, most likely the action was effective. However,if continued M&E reveals the level of performance for an indicator is unchanged, then no improvement has occurred and the action was probably ineffective. In the case of no improvement, further actions are necessary, should be taken, and their effectiveness assessed (Parsek, 1989). Thus, the effectiveness of actions is determined by continued monitoring (JCAHO, 1991).

CQI: It should be determined whether the actions taken are actually improving care/service and if so, this improvement should be maintained. If there is no improvement, further action should be determined and then this action assessed for its effect on improvement. This process is repeated until improvement is attained and sustained. Monitoring is continued and there is a periodic reassessment of indicators and monitoring priorities. In comparison with current M&E, this CQI approach emphasizes a sustained improvement over time (JCAHO, 1991b).

Step 10: Current: Communicate Relevant Information to the Organization-wide Quality Assurance Program.

CQI: Communicate Results to Relevant Individuals and Groups

Current: Findings and conclusions from M&E, as well as actions taken to improve care, are reported to the quality assurance program. This information is disseminated as necessary, as this will help to assure that QA findings are used toward improving patient care. This information must be documented as outlined in the organizationwide

quality assurance written plan. Conclusions, recommendations and actions should always be included in the reports and minutes of quality assurance activities (JCAHO, 1990c).

CQI: Conclusions, recommendations, actions and follow-up are reported by the teams performing the monitoring. These findings are reported/forwarded to relevant individuals and groups as well as leaders. Information is disseminated as necessary by the involved team and leaders throughout the organization. Comments, reactions, and information on the effectiveness of M&E received by the leaders and others from involved groups/individuals should be shared with relevant personnel (JCAHO, 1991b).

In summary, the modifications to the M&E process primarily involve:

- stressing leadership's role in the improvement of quality;
- extending the scope of quality assessment and improvement activities to include the related processes of governance, management, support and clinical services affecting patient outcomes rather than focusing solely on clinical processes;
- going beyond ongoing monitoring for other sources of feedback to initiate evaluation, and therefore improvement, of patient care and services;
- avoiding compartmentalization of services within departments, with attention to customer-supplier relationships among departments;
- concentrating on the processes of care instead of individual performance;
- realizing the importance of continuous improvement instead of only identifying and solving problems; and
- sustaining improvement over time (JCAHO, 1991b).

CHAPTER V

IMPLICATIONS

Perhaps one, if not the most significant, implication of CQI and the new nursing standards is the strengthened voice they give to nursing. The standards, developed by a committee of 24 nurses representing a variety of backgrounds and organizations, will give nurses more say in patient care and hospital operations. These standards are presented in detail in Chapter four of this paper.

Registered nurse (R.N.) decision making, arrived at by performing a patient assessment and formulating nursing diagnosis(es) and/or patient care problems, is delineated in Standard one (Patterson, 1991). Standard one addresses the cooperative relationship of nursing with other hospital services. This standard also identifies the need for permanently integrating specific nursing documentation into a clinical information system but does away with the requirement of a specific nursing care plan (Hurley, 1991).

Standard two speaks to the competence of the nursing staff and requires float nurses to receive orientation and cross training that is both adequate and timely as determined individually by each hospital. Standard three specifically designates nurses as being responsible for developing standards of practice and for planning patient care. The nursing executive or an appointee is required to be involved in the admissions system for aligning available nursing resources with patient needs. Another "increased voice" is that nurses must be included in addressing ethical issues regardless of the mechanism used by the hospital to address ethical decisions. Many nurses may be pleased with the new requirement for a policy review every three years as opposed to the previously required annual review. This is intended to allow a more thorough review with incorporation of any relevant material such as research findings, legal and ethical issues and relevance of procedures.

Standard four addresses the need for a nursing plan of care reflecting the organizational mission and supporting innovation and improvement in nursing practice. Standard five requires there be one designated single nurse executive for every hospital. Additionally, the nurse executive and other nursing leaders participate with other hospital leaders in developing the organization's mission statement and strategic plan, quality improvement activities and the nursing budget (Hurley, 1991). Quality assurance activities are still required by the new standards; however, this is outlined in the "Quality Assessment and Improvement" chapter of the 1992 AMH versus the "Nursing Care" chapter in the 1991 AMH.

The emphasis of the Agenda for Change and CQI on the assessment of patient outcomes and the continuous improvement of patient care quality has implications for nursing research. Perhaps the most important and compelling questions to be answered by future nursing research activities are evaluation of the Joint Commission revised standards and the CQI movement to determine if they bring about the changes and improvement in quality of care that they propose. The improvement of patient care outcomes requires focusing on structure effectiveness and care processes which lead to research questions. For example, the rate or frequency of an event is determined. If this rate is acceptable, it should be determined if the rate can be improved. If the rate is unacceptable, questions concerning performance issues and patient factors should be addressed. Patient factors should be examined to determine if there are different or better means for caring for these patients. Likewise, if analysis of a particular indicator rate reveals that practitioners delivered care in accordance with standards of practice despite not achieving expected outcomes or an unacceptable rate, research questions should be suggested. Suggestions may include studies testing different approaches to similar patient needs or

populations (Nadzam, 1991). The increased focus on patient outcomes and "insistence on high value of health care will lead to additional research questions for nursing and support for determining the most efficacious, effective and efficient interventions" (Nadzam, 1991, p. 21). Implementing nursing research activities or using others' research findings can provide scientific reasoning and lend support to suggestions for improving and changing practice (Katz & Green, 1991). Lawson, as cited in Katz & Green (1991, p. 56) states "research conducted by nurses, as well as nursing collaboration in interdisciplinary scientific inquiry, validates existing practice and provides new direction for enhancing care".

Leming (1991) states that many health care organizations are recognizing the need to take a more customer-oriented approach for delivering health care in order to satisfy consumers' needs and wants, and to compete in a dwindling market place. As emphasized by Deming, organizations have both internal and external customers. Patients, seen as external customers of health care organizations or consumers, are more educated and demanding than ever before. Health care is a service provided to consumers by health care workers (Gillem,1988). Consumerism has prompted increased patient involvement in and questioning of health care. Patients rights movements have added to patients' knowledge base for making more educated decisions regarding their health care (Leming, 1991). Consumers' expectations and perceptions of quality is a matter of great importance in CQI activities and efforts.

Albrecht and Zemke, as cited in Leming (1991), describe two types of services, primary and secondary. Health care providers are knowledgeable about providing primary services which include medical treatment, nursing care and hospital accommodations. It is the secondary services such as convenience items and personal courtesy where health care staff lack knowledge. Health care providers must provide

both types of services to help increase patient satisfaction. Customer services may ensure an organization's survival by eliminating unnecessary resources spent on resolving patient problems and complaints. Quality customer services do not cost more. Waste and rework is reduced by performing a service correctly the first time. Today's health care customer values doing things right the first time (Leming, 1991). Jones (1991) states that research indicates cost-effective care can equate with high quality care.

The consumer/customer approach should prove beneficial to health care organizations. Complaints made by patients and families should receive prompt attention. Fiesta (1991) cites an unhappy patient or family, rather than malpractice per se, as the fundamental cause of malpractice claims. Poor quality equates with poor outcomes--which equates to dissatisfied customers, extended hospitalizations, and even the payment of lawsuit settlements. Improving patient quality contributes to an increased probability of desired patient outcomes, including patient satisfaction. The question should not be "Can we afford high quality" but rather "Can we afford poor quality outcomes?"

Nurses, by way of their continual relationship with patients and families, are in an excellent position to elicit customers' wants and expectations. These implications do not lie only within nursing. An organizationwide effort and commitment towards quality, putting the customer first, must be assumed by leadership and management. Consumer research should be undertaken in the area of quality services and developing service strategies. Organizational decisions can be made based upon research suggestive of those services identified as valued by customers (Leming, 1991). An understanding of the consumer's perspective of quality is a necessary prerequisite to meet the quality outcomes demanded by society. "Perhaps crucial to the survival of

health care agencies in the 1990s is the extent to which organizations are consumer driven" (Taylor, Hudson & Keeling, 1991, p. 25).

To state that nursing has in the past and will continue in the future to contribute to quality care is an understatement. According to a survey reported by Koska (1989) asking 663 hospital Chief Executive Officers to rank order the most significant factors contributing to providing high quality care, nursing care was ranked as the most important contributor to the quality of care provided by a hospital. The research findings of Chassin, et al, (1989); Scott, Forrest & Brown, (1976); and Shortell & Hughes, (1988) as cited by Jones (1991) indicate that nursing is an important factor explaining the differences in death rates among hospitals.

CQI has implications for staff involvement at all levels. The responsibility for improving patient care quality will rest with each and every staff member. New & New (1989) advocate staff nurse involvement in QA activities. They believe staff nurses are closest to the patient and have a working knowledge of the real problems and can therefore develop realistic solutions that they themselves will implement at the unit level.

Smeltzer, Hinshaw and Feltman (1987) propose that involving staff nurses in QA may result in the following benefits:

- Increased understanding of the evaluation of nursing care which may lead to changes in and improvement of nursing practice.
- Increased staff cooperation with QA activities.
- Peer teaching about the importance of QA
- Knowledge of both positive and negative patient care aspects on the staff nurses' own unit and in comparison with other units.
- Increased nursing staff professionalism resulting from peer review.
- Enhanced credibility of QA.

A basic element of CQI is empowering staff to plan and implement opportunities for improving hospital operations (Jones, 1991). Staff must not only be committed to, but ready, willing and able to accomplish the organization's mission. The development of decision making and collaboration skills of staff members is a prerequisite for empowerment. Staff must learn to use judgement, plan, work with other staff and abide by end results of their efforts versus passing problems on to managers or complaining (Schroeder, 1992).

Empowerment requires efforts on the part of the organization as well. They must make the necessary preparations and changes to support staff empowerment. Structural aspects of the organization must accommodate communication and action-taking. Staff judgement must be trusted and staff levels closest to the action or decision must be supported in their decision making (Schroeder, 1992).

Implications of CQI expand to the clinical nurse specialist (CNS) position. Ricciardi and Kuck (1992) discuss the CNS role in QA and improving patient outcomes. The CNS has a fundamental role in facilitating and communicating the QA process. Each of the dimensions of the CNS role, expert in clinical practice, educator, consultant, researcher and administrator, as defined by the American Nurses Association (ANA) has significance to the QA process (ANA, 1986).

The administrator role of the CNS is utilized through communication with hospital staff and addressing QA issues. A knowledge of research allows the CNS to assist staff nurses in evaluating and analyzing patient care issues. Involvement in patient care issues throughout the hospital is afforded the CNS through the consultant role. As an educator, the CNS can teach the QA process to other staff. Expertise in clinical practice allows the CNS, in conjunction with other staff members, to identify issues for QA evaluation. Some of the CNS

role functions described in a QA plan described by Ricciardi and Kuck (1992) include the following:

- Development and implementation of standards of care and practice for monitoring outcomes and improving care.
- Monitoring nursing practice and the health care environment for changes or trends influencing QA.
- Participation in QA criteria (indicator) development.
- Collaboration in designing research studies and analyzing such data.
- Participating in the development and execution of improvement plans.
- Using QA findings as a basis for facilitating change.
- Acting as liaison between unit and nursing practice committees.
- Participation in a "Nursing Quality Assurance Steering Committee".
- Participating in interdepartmental, nursing, and medical research studies.

Involving staff in CQI activities, such as self assessment programs similar to the SIR, and monitoring and evaluation efforts can increase their awareness and understanding of standards. New and New (1989) believe professional development of staff nurses is enhanced by involving staff in QA efforts. Tierney, Grant & Mazique (1990) encourage the CNS's involvement in developing hospital programs that will increase revenue and enhance the hospital's image. Additionally, they believe the CNS should facilitate the process of meeting JCAHO standards. Assuring compliance to JCAHO standards should never be taken lightly as standards promulgated by the JCAHO may be considered by a jury in determining negligence (Southwick, 1988). If negligence is found, damages will most likely follow. Thus, adhering to JCAHO standards may be viewed as cost effective from a liability viewpoint. In addition, failure or loss of accreditation by JCAHO can result in loss of monies for medical school affiliations (and therefore loss of resident and intern education programs) and loss of third party

reimbursement payments. There is also a stigma associated with failing a JCAHO accreditation that may effect ones sanction within the profession.

The importance of staff involvement cannot be stressed enough. All staff must be able to articulate the organization's mission and CQI principles and activities. Staff participation and commitment must be solicited and valued. Sawyer-Richards (1990) proposes using a marketing concept as a management strategy for dispelling the negative image frequently associated with QA and improving nursing staff's commitment and participation in CQI activities. This marketing concept focuses on QA outcomes and benefits to patients, staff, consumers and the hospital and community. It involves using motivational techniques and communication strategies to promote the positive aspects of QI activities. Nurses are recognized as having the ability to make a significant difference in, and contribution to, the patient care delivery system.

There are numerous benefits resulting from improved quality of patient care. Benefits to the organization include, in addition to the ultimate goal of high quality care, resolving problems and improving processes that contribute to unnecessary use of resources. Decreasing avoidable complications which result in extended hospitalizations is another benefit. Documented results of CQI efforts can show both internal and external customers that safe, effective, and efficient care is delivered by the health care organization. This can only help marketing efforts and contribute to the organization's success (JCAHO, 1988b).

Benefits for the practitioner include realizing the resultant improvement in quality care from CQI activities. Additionally, practitioners can learn the components of high quality care, more effective methods of identifying needs, treatments and areas requiring

more research and information. The patient, and rightly so, is the ultimate beneficiary of CQI. The availability of timely, effective and cost-efficient high quality care is wanted and expected by many health care consumers (JCAHO, 1988b).

The time factor involved in implementing the CQI process must be recognized and respected. Although many people expect to see instant results, Ellen Gaucher, University of Michigan Hospitals' chief operating officer and director of the total QI process, states that it takes a minimum of six months for employees to comprehend and apply CQI to their jobs. Gaucher also makes important points concerning the slow process of changing an organizational culture through empowering employees, driving out fear, and moving from a "superstar" concept to a teamwork approach. Because CQI is expensive and resource intensive in the early phases, it is a difficult process. It is essential to view CQI as an investment in the future (Hospital Peer Review, 1990b).

A final note worthy of repetition is the vital importance of the commitment, and active participation of organizational leadership to CQI. They must "walk the talk". After CQI standards and philosophies are in place, action is required, not lip service. The responsibility for quality no longer rests with a few people assigned to a QA department, rather the responsibility rests with each and every member of an organization, irregardless of where they work or what they do.

CHAPTER VI

CONCLUSION

Standards are crucial to the practice of any profession. The new and revised JCAHO standards aim for progression and continuous improvement of the quality of patient care. They define the actions and outcomes for which staff will be held accountable (Katz & Green, 1991).

All staff should be familiar with standards applicable to their practice. Additionally, standards should guide everyday practice rather than having staff's awareness of, and compliance to JCAHO standards increase shortly before Joint Commission accreditation visits as eluded to by Brubakken (1991).

The implementation of CQI does not have to be a grueling process. It does require the sustained commitment of each and every employee to the improvement of quality. The patience and resources required to complete the cultural change necessary to adapt a CQI philosophy should not be overlooked nor underestimated.

A CQI philosophy holds that quality can always be improved. Quality cannot be improved by inspection, rather it must be ingrained in the processes and people performing the work of the organization (Schroeder, 1991b). It is doubtful the CQI movement will fade away. Schroeder (1991b) believes the concept of improving quality will continue into the 21st century. The JCAHO has begun to emphasize and integrate CQI principles into its standards, literature and activities. In today's highly competitive and rapidly changing health care environment, the time for CQI is now. It is appropriate to conclude with a quote from Dennis O'Leary, current president of JCAHO, (as cited in Schroeder, 1991b, p. 5), "In retrospect, the word `assurance' was an unfortunate semantic selection. Quality of course, could never be assured. Rather it could at best only be improved".

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Abstract

The concept of quality in health care is discussed throughout this paper, within an historical perspective, including key forces influencing quality assurance (QA).

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has been identified by Schroeder (1991a) as probably the most significant influence on QA structures and approaches in the United States. The revised nursing care standards delineated by JCAHO in the 1991 Accreditation Manual for Hospitals (AMH) will be discussed in this paper. A Systematic Internal Review (SIR) program to be utilized as a self assessment of compliance with the new standards is introduced. In addition, the monitoring and evaluation (M&E) process used to measure the quality of care as set forth by JCAHO is described.

The concept of quality and the shift from a traditional QA philosophy to a continuous quality improvement (CQI) philosophy is explored with implications for health care and nursing presented. The importance of nursing staff as well as an organizationwide commitment to and involvement with CQI activities is emphasized.

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